NEW PATIENT INFORMATION

Patient's last name:	First:	M.I:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Email Address:	DOB:	Age:	Sex:

Street Address:	SSN:	Preferred Phone No.:
		( )

P.O. box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer phone no.:
		( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

May we leave a detailed message at all phone numbers/email? (circle one)	Yes No

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )

Is this person a patient here?	❑ Yes	❑ No	

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance	❑ Medicaid	❑ Medicare	❑ Anthem B/C B/S	❑ United Health Care	❑ Cigna
❑ Rocky Mountain Health	❑ AARP	❑ Colorado Access	❑Rail Road Medicare	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elite Foot and Ankle Clinic or insurance company to release any information required to process my claims. I authorize release of any previous medical records by fax, mail, or phone by either physician or hospital generated. I also hereby authorize the doctor and/or her assistants to initiate the diagnosis and treatment of my condition with x-ray, examination, or photographs of my condition as medically necessary.

Patient/Guardian signature	*Date*

Patient Information

Please list any major events, hospitalizations, surgeries … etc.…

Reason: ____ Month/Year: __________

Reason: ____ Month/Year: __________

Reason: ____ Month/Year: __________

Reason: ____ Month/Year: __________

Personal Medical History

Please check all that apply:	
Blood Clots	Anemia
Chest Pain on Mild Exertion	Arthritis
Diabetes	Rheumatoid Arthritis
Dialysis M W F or T TH SA	Asthma
Migraines	Drug/Alcohol Abuse
Emphysema	Epilepsy or Seizures
Frequent Headaches	High Blood Pressure
Gout	Pneumonia
Osteoporosis	Prostate Disorder
Kidney Disease	Psychiatric Treatment
Heart Attack	Sexually Transmitted Disease
Stroke	Stomach Ulcer
Tuberculosis	Hyperthyroid
Tumor/Abnormal Growth/Cancer	Hypothyroid
Frequent Infection	Liver Disease
Mental Illness (specify)	Lung Disease
Peripheral Vascular Disease	Other (specify):

FAMILY HISTORY

(Please check all boxes that apply)

DIAGNOSIS	MOTHER	FATHER	MOTHER'S PARENTS	FATHER'S PARENTS	SIBILINGS	CHILDREN
Cancer (specify):						
Heart Attack:						
Arrhythmia:						
Stroke:						
Osteoarthritis:						
Blood Clots:						
Bleeding Disorder:						
Feet Problems (specify):						
Diabetes:						
High Blood Pressure:						
Mental Illness:						
Tuberculosis:						
Other (specify):						

Name____ DOB:_________________________

Social History

Section 1:Tobacco	
Smoke cigarettes:(If you never smoked please go to Section 2)	□ Never □ Yes □ No
Quit date: ______	
How many years did you smoke?	
Approximately how many packs a day did you smoke?	
Current smoker: Packs/day: _________	
# of years: _________	
Other tobacco:	□ Pipe □ Cigar □ Snuff □ Chew
Section 2: Alcohol	
Do you drink alcohol?	□ Yes □ No
# of drinks/week: ___________	
Type?	□ Beer □ Wine □ Liquor
Section 3: Recreational Drugs	
Do you use marijuana or recreational drugs?	□ Yes □ No
(If yes) Type:	
Have you ever used needles to inject drugs?	□ Yes □ No
Additional information:	
Do you drink caffeine?	□ Yes □ No
If yes, how many cups per day?	_____cups
Do you exercise?	□ Yes □ No
If yes, how often?	_____ times/week
If yes, what type of exercise?	

Height: _____	Weight: _____	Shoe size: _____
Ethnicity:	Race:	
Preferred Pharmacy:	Phone #:	
Location:		

Review Of Systems

Please check all that apply (in the past 6 months):

Changes in nails	Heart murmurs
New skin lesions	Heart palpitations
Ringing in ears	Chest pain
Hoarseness	Change in Appetite
Sore Throat	Diarrhea
Shortness of breath/ wheezing	Constipation
Pain urination	Blood in urine
Anxiety	Changes in vision
Unexpected weight gain	Unexpected weight loss
Depression	Mental Illness

Please tell us what brings you to our office:

____

____

Name____ DOB:___________________________

Medications

Please list all medication you are currently taking including over the counter and vitamins (example: Tylenol 1 600mg tablet every 6hrs as needed)

Name of Medication	Dosage (ex: g, mg, mcg)	Frequency (ex: 1 pill 2x a day)

Please list any/all Allergies (food, drug…etc…), please include your reaction

Name of Allergen	Reaction

Name____ DOB:______________________________

Acknowledgement of Recipt of Privacy Notice

I have received a copy of Elite Foot and Ankle Clinic's Notice of Privacy Practice, which details how my personal health information may be used and disclosed as permitted under federal and state laws. I have read and understand the contents of the notice.

Authorized Personnel/ Patient Signature: ______________________________ Date:_______

If not signed by the patient, please indicate the relationship to the patient.

Relationship: ___________________________

Internal Use Only

If a patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time): ____

By (name and title): ____

Consent to Enroll into Electronic Personal Health Record

Per Medicare Guidelines we are required to inform you that you are able to have access to your personal health information. To access your information please provide your email address. If you do not have your own, with your consent, we may use a family member's email address. If no other email address is available to you, we are more than happy to assist you in opening a new email account.

Email address: ____________________________________

If this email address is not your own please list the name and relationship to whom the email address belongs: ____

Your signature indicates your understanding and consent to being enrolled in our online patient portal that will allow you timely access to your electronic personal heath record.

Patient's Name: ___________________________________

Patient/Guardian Signature _____________________________

Date: _______________________________

Name____ DOB:_________________________

We now have the ability to email and/or text you, reminding you of your appointments. If you would like to receive this feature, please read the consent below and sign.

Consent to email and/or text message for appointment reminders and other healthcare communications:

Patients in our practice may be contacted via voicemail, email and/or text messaging to remind you of an upcoming appointment, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information via voicemail, email and/or text from Elite Foot and Ankle Clinic.

_______ (Patient/guardian initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive voicemails, text messages for appointment reminders, and general health information is

(________)-___________-___________________ Carrier:______________________

_______(Patient/guardian initials) I consent to receive email communications as stated above.

The email that I authorize to receive email messages for appointment reminders and general health reminders/information is

____________________________________@____________________.com

-I understand that this request to receive voicemails, emails and/or text messages will apply to all future appointment reminders/health information unless I request a change in writing.

Patient/guardian signature:____

Name____ DOB:_________________________