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Patient Information

Last name: ____________________ First name_____________________ Age_______ DOB _____/______/______
Sex M F Social Security # ______-____-______
Mailing Address:____
City_________________________State__________ Zip___________
Phone (check preferred number) ☐ Cell ______________________________ ☐ Home ___________________________
☐ Work ____________________________________
Email____
Emergency Contact__________________________ Phone #__________________ Relationship to patient:_______________
If patient is a minor: Responsible Party's Name:___________________________ Relationship to Minor:________________
How did you hear about us? ____
Primary Care Physician: ____ Phone: ___________________________
Persons authorized to access my medical information:____
____

Insurance: Company_________________________ID#________________________Group/Policy#___________________

Name of Policy Holder__________ ______________ SS#______-_____-________ DOB _____________________________
Is referral required? Yes No (patient responsible to obtain referrals)

Secondary Insurance__________________________ID___________________________Group________________________
Name of Policy Holder_________________________ SS#______-_____-________ Relationship to patient______________

Today's Problem

Describe today's problem(s):____

How long have you had the problem:____

Rate the pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10

What makes the problem worse:____

What make the problem better:____

What have tried to treat the problem:____

Please mark the location of today's problem(s):

LEFT FOOT

RIGHT FOOT

TOP OF FOOT

BOTTOM OF FOOT

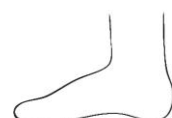
BOTTOM OF FOOT

TOP OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

Allergies/Sensitivities: ____

____

Current medications/supplements (or provide us with a **complete** copy of your current medications):

Medication:________________________________Dose:__________Frequency:____________________
Medication:________________________________Dose:__________Frequency:____________________
Medication:________________________________Dose:__________Frequency:____________________
Medication:________________________________Dose:__________Frequency:____________________
Medication:________________________________Dose:__________Frequency:____________________

Preferred Pharmacy:______________________________**Location:**______________________________

Medical History – Please indicate if you, personally, have experienced any of the following:

□ No major illness or other prior medical conditions

Cardiovascular
___Peripheral Artery Disease
___Peripheral Vein Disease
___High Blood Pressure
___High Cholesterol
___Atrial Fibrillation/Arrhythmia
___Heart Attack
___Coronary Artery Disease
___Congestive Heart Failure
___Stroke/TIA
___Other:

Kidney
___Kidney Disease
___Kidney Failure
___Kidney Infection
___Kidney Stone
___Other:

Genitourinary
___Recurrent Urinary Tract Infections
___Prostate Enlargement
___Prostate Cancer
___Other:

Immune
___HIV
___Chronic Skin Infection
___MRSA
___Hepatitis A B C
___C. Difficile
___Other:

Respiratory
___Asthma
___Bronchitis
___COPD
___Emphysema
___Other:

Liver/Gall Bladder
___Cirrhosis
___Gall stones
___Other:

Endocrine
___Prediabetes
___Diabetes (insulin dependent)
___Diabetes (non-insulin dependent)
___Chronic steroid use
___Adrenal Disease
___Thyroid Disease
___Other:

Rheumatology
___Rheumatoid Arthritis
___Sjogren's Syndrome
___Raynaud's Syndrome
___Ehlers Danlos
___Seronegative Arthropathy
___Other:

Musculoskeletal
___Fibromyalgia
___Back/Neck Pain
___Osteoporosis/Osteopenia
___Osteoarthritis
___Gout
___Cysts
___Other:

Gastrointestinal
___Reflux/Heartburn
___Crohn's Disease
___Ulcerative Colitis
___Irritable Bowel Syndrome
___Bleeding Ulcers
___Other:

Dermatology
___Melanoma
___Squamous Cell Carcinoma
___Basal Cell Carcinoma
___Other:

Nervous/Psychiatric
___Seizure Disorder
___Multiple Sclerosis
___Parkinson's Disease
___Depression/Anxiety
___Peripheral Neuropathy
___Other:

Hematologic
___Bleeding Disorder
___Clotting Disorder
___Platelet Disorder
___DVT/Blood Clots
___Other:

Other medical conditions not listed above:____

____

Cancer history, including type:____

____

List any prior complications with anesthesia:____

____

Are you pregnant? ___Yes ___No Are you nursing? ___Yes ___No

Surgical History – Please list ALL surgeries you have had:

Surgery:	Year:	Surgery:	Year:

Family History – Please check any known health conditions in your family:

- □ Alcoholism
- □ Amputation
- □ Anemia
- □ Anxiety/Depression
- □ Arthritis
- □ Cancer
- □ Diabetes Type 1
- □ Diabetes Type 2
- □ Heart Attack
- □ High blood pressure
- □ Kidney Disease
- □ Peripheral Vascular Disease
- □ Stroke

Other:____

Social History

Tobacco Use: _______Never _______Year quit _______Current Packs per day:________________

Alcohol Use: _______Never _______Year quit _______Current Amount/frequency:_____________

Drug Use: _______Never _______Year quit _______Current Type:______________________

Occupation:____

Marital Status: Single Married Separated Divorced Widowed

Please provide any other pertinent information:____

Medical Information Release

I acknowledge that I have been offered a copy of the NOTICE OF PRIVACY POLICY of **Treasure Valley Foot and Ankle** ("TVFA") and that TVFA may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that TVFA may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize TVFA to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, film/images, and other clinic information deemed necessary by TVFA physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with TVFA's privacy policy.

Consent for Treatment

I hereby consent to the medical treatment, diagnostic, and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). EAF will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Financial Responsibility and Agreement

I hereby authorize any benefits due me to be paid directly to Treasure Valley Foot and Ankle. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, co-pay or non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier which could include orthotics, braces, splints, over-the-counter medications, heel cups, pads, toe separators, etc. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits, including obtaining a valid referral from my primary care physician, if necessary. All delinquent accounts will be charged an interest rate of 1.5% per month 18% per annum. In the event any balance is not paid as agreed, I agree to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, I further agree to pay court costs and reasonable attorney fees. I agree, to permit TVFA to service my account or to collect any amounts I may owe, and to contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. TVFA may also contact me by sending text messages or e-mails, using any email address I provide to them. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable. In consideration for medical services rendered, I acknowledge that I have access to TVFA's financial policy and agree to pay for said medical services according to such terms. To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status. (ver. Jan 2019)

Patient/Responsible Party Signature:____ Date:__________