GLACIER
FOOT *and* ANKLE
ASSOCIATES

95 Indian Trail Road • Kalispell, MT 59901 • (406) 755-1300

PATIENT INFORMATION

Last Name ____________ First Name ____________ MI ______

Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Work Phone ____________

Birthdate ____________ Social Security # ____________ Age ______ Sex M F

Marital Status M S W D Employer ____________ Occupation ____________

* If patient is a minor, please complete Parent/Guardian Information

PARENT/GUARDIAN INFORMATION

Name ____________ Social Security # ____________

Address ____________ Phone ____________

Employer ____________ Work Phone ____________

INSURANCE INFORMATION

Primary Insurance ____________

Subscriber Name ____________ Phone ____________

Subscriber ID ____________

Secondary Insurance ____________

Subscriber Name ____________ Phone ____________

Subscriber ID ____________

Please inform front desk if this is related to workers comp.

EMERGENCY INFORMATION

Name of relative or friend not living with you ____________

Relationship ____________ Address ____________ Phone ____________

I give permission to Glacier Foot & Ankle Associates to administer to me such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition. I understand that I am solely responsible for this consent, and that I am financially responsible for all charges, whether or not paid by my insurance. I hereby authorize Glacier Foot & Ankle Associates to release all information necessary to secure payment.

We will submit insurance claim forms, however, Medicare/many insurance carriers do not cover “routine” foot care, i.e. nail trimming, corns and calluses unless medically necessary. You will be responsible for any charges that Medicare/your insurance denies as “routine.”

Our goal is to provide caring and highly competent foot care. We can only do this with your help. Please feel free to comment on any aspect of your visit which you feel needs our attention.

____________________ ____________

Patient or Guardian Signature Date

Please fill out the back side

MEDICAL HEALTH & HISTORY

Referred by: ❑ Phonebook ❑ Friend ❑ Newspaper ❑ Other ______

Describe your foot problem: Primary Care Physician: ______ Date last seen: ___/___/___

Right foot: ______

Left foot: ______

Height ______ Weight ______ Shoe size ______

Have you ever been seen by a podiatrist before? Y N Whom and when? ______

Have you had any serious illness in the last three years? ______

Surgical history: ______

Medications: ______

______

FAMILY HISTORY WHO?

			Who?
Heart Disease	Y	N	______
Diabetes	Y	N	______
High Blood Pressure	Y	N	______
Cancer	Y	N	______
Foot Problems	Y	N	______

ALLERGY

Are you allergic or have you reacted adversely to any of the following?

Local Anesthesia	Y	N	Penicillin	Y	N
Aspirin	Y	N	Sulfa Drugs	Y	N
Anti-inflammatories	Y	N	Other antibiotic	Y	N
Tape or Band-Aids	Y	N	Codeine	Y	N
Latex	Y	N	Sedatives	Y	N
Iodine	Y	N	Other ______		

Type of Reaction ______

PAST MEDICAL HISTORY

Are you being treated for or have you ever been treated for:

Gout	Y	N
Reaction to anesthesia	Y	N
Hepatitis	Y	N
type ______		
Liver disease/jaundice	Y	N
Skin Rashes or Hives	Y	N
Epilepsy or Seizures	Y	N
Kidney Trouble	Y	N
Emphysema or bronchitis	Y	N
Asthma	Y	N
Tuberculosis	Y	N
Scarring tendency	Y	N
HIV/Aids	Y	N
Women, are you pregnant?	Y	N
Breast Feeding	Y	N

Diabetes	Y	N
yrs ______ type ______		
High Cholesterol	Y	N
High Blood Pressure	Y	N
Heart Problems	Y	N
type ______		
Heart Attack/Stroke	Y	N
Stomach Ulcers	Y	N
Arthritis	Y	N
Artificial joints or heart valve	Y	N
Rheumatic Fever	Y	N
Cancer or tumor	Y	N
Bleeding Problem	Y	N
Anemia	Y	N
Thyroid Problem	Y	N
Blood Clot, DVT, Phlebitis	Y	N

Do you smoke? Y N If so, how many each day? ______ How long? ______ Quit? ______

Do you drink alcohol? Y N If so, how much? ______ How often? ______