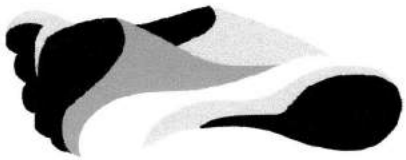


Flathead Family Foot Care

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (___) ___-_____ YES NO

ALTERNATE PHONE #: (___) ___-_____ YES NO

E-MAIL: _____ YES NO

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

HOW DID YOU HEAR ABOUT US: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (___) ___-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ NO _____ YES NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME DOSE HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY DATE TYPE OF SURGERY DATE

_____ _____
_____ _____
_____ _____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION DATE REASON FOR HOSPITALIZATION DATE

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ **OCCUPATION:** _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

WHO DO YOU LIVE WITH? ☐ SPOUSE ☐ PARTNER – NAME_____ ☐ CHILDREN–AGE(S) _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY:

	DIABETES	CANCER	HEART DISEASE	STROKE	BLOOD CLOTS	HIGH BLOOD PRESSURE	RHEUMATOID ARTHRITIS	OTHER:
MOTHER								
FATHER								
OTHER								

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

A-FIB (ATRIAL FIBRILLATION)	Y	N	DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OTHER MENTAL HEALTH CONDITION:_____	Y	N
ANXIETY/DEPRESSION	Y	N	HEARING LOSS	Y	N	PARKINSON'S DISEASE	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	RHEUMATOID ARTHRITIS	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	SEIZURES	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	SICKLE CELL DISEASE	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SKIN DISORDER TYPE:_____	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SLEEP APNEA	Y	N
BLOOD CLOTS	Y	N	HIGH CHOLESTEROL	Y	N	STOMACH ULCERS	Y	N
BLOOD TRANSFUSION	Y	N	KIDNEY DISEASE	Y	N	STROKE	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LIVER DISEASE	Y	N	THYROID DISEASE	Y	N
CANCER (LOCATION:_____)	Y	N	MIGRAINE HEADACHES	Y	N	TUBERCULOSIS	Y	N

OTHER CONDITIONS:

Describe any recent or ongoing symptoms with your general health:

Constitutional: Fever, chills, unexplained weight change, unexplained falls?_____
Head, Eyes, Ears, Nose, Throat: Difficulty hearing, seeing, nosebleeds, difficulty swallowing?_____
Cardiovascular: Chest pain, leg swelling, irregular heartbeat, pain in calf while walking?_____
Respiratory: Shortness of breath, cough, wheeze?_____
Neurologic: Dizziness, numbness, tingling, weakness, tremor?_____
Gastrointestinal: Heartburn, nausea, vomiting, diarrhea, stomach ulcer, blood in stool?_____
Genitourinary: Frequent urination, trouble urinating, blood in urine?_____
Musculoskeletal: Joint pain, joint swelling, joint redness, joint stiffness?_____
Skin: Dry skin, wounds, itching, rash, foot/ankle ulcer?_____
Hematologic: Prolonged or excessive bleeding, easy bruising? _____
Endocrine: Frequent hunger, frequent thirst, heat or cold intolerance? _____
Other symptoms? _____

What types of shoes do you most often use?_____
What is your Height _____ Weight _____ Shoe size _____?
Any other health concerns that your doctor may need to know?

_____

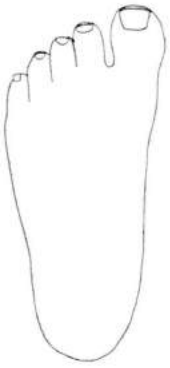
PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

CURRENT PROBLEM

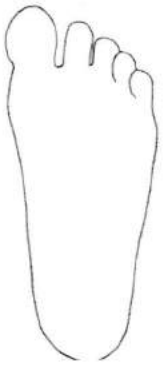
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT



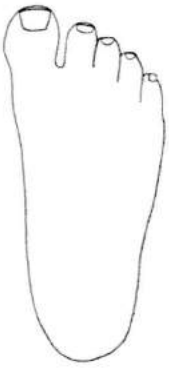
BOTTOM OF FOOT

INSIDE OF FOOT

OUTSIDE OF FOOT

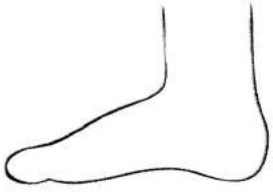
RIGHT FOOT

BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED ALL OF THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT MEDICAL 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.

_____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

Flathead Family Foot Care PC

I, the undersigned certify that I (or my Dependent) have insurance coverage with _____ and assign directly to Flathead Family Foot Care PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, such as copays, deductibles and non-covered services. I hereby authorize Flathead Family Foot Care PC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby give permission to Flathead Family Foot Care PC and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

_____
Patient or Authorized Signature/Date

Although we make every attempt to be thorough with the information given at the time of scheduling appointments, it has come to our attention that some insurance companies have various plans that we may not be a part of. Ultimately it is your responsibility to check with your insurance company to see if we are IN NETWORK or if referrals are needed from your primary care physician.

Notifier:
Patient Name: **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.

We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	☐ Cutting of corns, calluses, or toenails ☐ Cosmetic or hygienic care or treatments ☐ Orthotics, arch supports, braces – not permanently attached to a custom shoe ☐ Protective toe/foot devices or protective non-Rx "balance pads" ☐ Items of convenience otherwise available at retail establishments but not normally included as part of a medical treatment ☐ Other: (Present pricing supplied prior to dispensing above)	("Routine"/Palliative Foot Care) (Cosmetic surgery) (Devices inserted in your shoes) (Protective shoe or pads) (Medications and/or home dressings)	
Reason Medicare May Not Pay:	**The above items are statutorily non-covered services under Part B Medicare.**		
Estimated Cost:	Estimated cost will depend on item checked above. Actual cost/s will be provided IN-ADVANCE of providing any above service.		

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: **Check only one box. We cannot choose a box for you.**

- ❑ **OPTION 1.** I want the service listed above. I may be asked pay now. I wish to personally bill Medicare for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, I will directly receive any payments made, less co-pays or deductibles.
- ❑ **OPTION 2.** I want the service listed above, but do not require Medicare to be billed. You will be asked to pay now for said service. I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- ❑ **OPTION 3.** I don't want the service listed above. I understand with this choice I am **not responsible for any payment** for said service/s, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may also receive a copy.

Signature:	**Date:**