Sole Foot & Ankle Specialists

Dr. Jay C. Larson
Dr. Dustin R. Doyle

# PATIENT INFORMATION

Patient's Name_____ Patient's Social Security_____

Patient's Address_____ Birthdate_____/_____/_____ Age_____

City_____ State_____ Zip_____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep ☐ Other

Cell Phone #_____ Spouse Name_____

Home Phone #_____ Email _____

Responsible Party (if minor)_____ **Appointment Reminders?** ☐ Text ☐ Phone Call

**Race/Ethnicity**: ☐ Caucasian/White ☐ Black/African American ☐ Asian ☐ Latin/Hispanic ☐ Native Hawaiian/Pacific Islander

☐ Native American/Alaska Native ☐ Other_____ **Primary Language:**_____

**EMPLOYMENT INFORMATION** Patient/Parent Occupation_____

Patient/Parent Employer_____ Spouse's Employer _____

Employer Address_____ Employer Address _____

City_____ State_____ Zip_____ City_____ State_____ Zip_____

Employer Phone #_____ Employer Phone #_____

**INSURANCE INFORMATION - We will copy your insurance card but we need you to fill out this section**.

Primary Insurance _____ Secondary Insurance_____

Ins Co Address_____ Ins Co Address_____

City_____ State_____ Zip_____ City_____ State_____ Zip_____

Ins Co Phone #_____ Ins Co Phone #_____

Cardholder Name_____ Cardholder Name_____

Relationship to Patient _____ Relationship to Patient _____

Group #_____ ID#_____ Group #_____ ID #_____

Insured Date of Birth_____ Sex: ☐ M ☐ F Insured Date of Birth_____ Sex: ☐ M ☐ F

**ACCIDENT INFORMATION** (If the reason you are here today is from an accident)

Date of Accident_____/_____/_____ How/Where_____

Work Related: ☐ Y ☐ N Were you treated by another Doctor for this injury? ☐ Y ☐ N

Doctor's Name_____ Phone #_____

Primary Care Doctor_____ Phone #_____

Former Podiatrist_____ Phone #_____

Preferred Pharmacy_____ Pharmacy Cross Streets_____

Referred by_____ Preferred Lab_____

**How Did You Learn About Our Office?** ☐ Doctor ☐ Patient ☐ Insurance ☐ Internet ☐ Other:_____

By signing this document:

1. I hereby give my permission to administer treatment, and to perform such procedures as may be necessary in diagnosis and treatment.
2. I will finish insurance forms & information and I agree to pay my co-payment, deductible and non-covered portions at the time of my visit or when billed by the office.
3. "Minors" I agree that I am the legal guardian of this patient, and understand that **only** the legal guardian is allowed in the exam room.
4. I understand that a photograph may be taken of me for insurance verification purposes, and if I disagree with this process I will let the office know.

Patient Signature:_____ Date:_____/_____/_____



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# MEDICAL HISTORY

**PATIENT NAME (LAST, FIRST, MI)**:_____

**PRESCRIPTION MEDICATIONS:**
(Please list all medications, attach a list if needed)

Medication:_____ Medication:_____
Medication:_____ Medication:_____
Medication:_____ Medication:_____
Medication:_____ Medication:_____

**ALLERGIES TO MEDICATIONS:**

Medication:_____ Reaction:_____ Medication:_____ Reaction:_____
Medication:_____ Reaction:_____ Medication:_____ Reaction:_____

**PREVIOUS SURGERIES:**

Type:_____ Year:_____ Type:_____ Year:_____
Type:_____ Year:_____ Type:_____ Year:_____
Type:_____ Year:_____ Type:_____ Year:_____
Type:_____ Year:_____ Type:_____ Year:_____

**SOCIAL HISTORY:**

Do you exercise? ☐ Y ☐ N Have you had the flu vaccine? ☐ Y ☐ N If yes, date_____/_____
History of drug abuse? ☐ Y ☐ N Have you had the Pneumonia vaccine? ☐ Y ☐ N If yes, date_____/_____
Do you drink alcohol? ☐ Y ☐ N Amount:_____
Do you smoke? ☐ Y ☐ N Amount:_____ Have you quit? ☐ Y ☐ N
Are you currently pregnant? ☐ Y ☐ N # of months: _____
Occupation_____ Does your job require you to: ☐ Carry ☐ Run ☐ Walk ☐ Climb ☐ Sit ☐ Lift ☐ Stand

**MEDICAL PROBLEMS:**
Please check if you have/have had the following:

☐ Neuropathy ☐ Gout ☐ High Blood Pressure
☐ Fibromyalgia ☐ Varicose Veins ☐ Heart Problems Type:_____
☐ Asthma ☐ COPD ☐ Arthritis Select: ☐ Rheumatoid ☐ Osteo
☐ Kidney Disease ☐ Anemia ☐ High Cholesterol
☐ Hepatitis Select: ☐ A ☐ B ☐ C ☐ Stroke ☐ Cancer
☐ Thyroid Problems ☐ Bleeding Disorder ☐ Low Back Pain
☐ Liver Trouble ☐ Blood Clots ☐ Artificial Joints
☐ Aids/HIV ☐ Stomach Problems: Type:_____
☐ Diabetes/Result of last Blood Sugar/HbA1c:_____
☐ Other:_____

**FAMILY HISTORY (SELECT ALL THAT APPLY):**

| | | | | |
|---|---|---|---|---|
| ☐ Hypertension | ☐ Mother | ☐ Father | ☐ Grandparent | ☐ Sibling |
| ☐ Heart Disease | ☐ Mother | ☐ Father | ☐ Grandparent | ☐ Sibling |
| ☐ Diabetes | ☐ Mother | ☐ Father | ☐ Grandparent | ☐ Sibling |
| ☐ Foot Problems | ☐ Mother | ☐ Father | ☐ Grandparent | ☐ Sibling |

**HEIGHT:**_____ **WEIGHT:**_____ **SHOE SIZE:**_____

*I understand that honest and complete answers to each question stated above are important to the provision of my medical care, and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form, I should ask the doctor or member of the medical staff for assistance. This information is true and accurate to my knowledge.

PATIENT SIGNATURE:_____ DATE:____/_____/_____

# CURRENT MEDICAL HISTORY

**Patient Name:**_____ **Date:**_____/_____/_____

**Please assist us by letting me know the reason you are here today:**

**Location:**_____
(Where is the pain/problem?)

**Quality:**_____
(Example: Does it ache, burn, etc? Pain after rest or after activity, etc?)

**Severity:**_____
(How severe is the pain on a scale of 1-5 with 5 being the most severe?)

**Timing:**_____
(Does the pain/problem occur at a specific time of the day?)

**Duration:**_____
(How long have you had this pain/problem? When did it start?)

**Context:**_____
(Where were you at the onset of the pain/problem?)

**Associated symptoms:**_____
(What other associated problems have you been having?)

**Modifying factors:**_____
(What makes the pain worse or better? Any previous episodes?)

**REVIEW OF SYSTEMS:**
Do you have any of the following:

**GENERAL:**
☐ Fever ☐ Chills ☐ Fatigue ☐ Weight Loss

**RESPIRATORY:**
☐ Shortness of Breath ☐ Coughing ☐ Difficulty Breathing ☐ Wheezing

**CARDIOVASCULAR:**
☐ Chest Pain ☐ Cramps in Legs & Feet ☐ Varicose Veins ☐ Swelling in Legs/Feet

**GASTROINTESTINAL:**
☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn

**MUSCULOSKELETAL:**
☐ Joint Pain ☐ Back Pain ☐ Knee Pain ☐ Muscle Pain/Weakness

**NEUROLOGICAL:**
☐ Numbness/Tingling ☐ Seizures ☐ Sciatica ☐ Headaches

**SKIN & NAILS:**
☐ Thick Nails ☐ Skin Dryness ☐ Rash ☐ Itchy Skin

**PSYCHIATRIC:**
☐ Depression ☐ Anxiety ☐ Panic Attacks

**ENDOCRINE:**
☐ Increased Thirst ☐ Cold or Heat Intolerant ☐ Post Menopausal

**HEMATOLOGICAL:**
☐ Anemia ☐ Easy Bruising ☐ Blood Thinners

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PATIENT SIGNATURE:_____ DATE:____/_____/_____



OVER →

# PATIENT FINANCIAL RESPONSIBILITY

I authorize the release of any medical information necessary to process claims for services I have been provided. I give permission to copy this authorization to be used in place of the original. I authorize Sole Foot & Ankle Specialists to apply for benefits on my behalf for any covered services performed. I request the payment from the insurance company be made directly to Sole Foot & Ankle Specialists. I authorize Sole Foot & Ankle Specialists to contact and forward any pertinent information to my insurance company regardless of whether or not they will provide payment. I certify that the above information is correct.
**Initial:**_____

**Minors:** I agree that I am the legal guardian of this patient, and understand that only the legal guardian is allowed in the exam room. **Initial:**_____

**Acknowledgment for Lab Services:** I have informed the office of the lab company that is contracted with my insurance. If I decide to go to a lab outside of network, I will be responsible for any billed charges. **Initial:**_____

**Acknowledgment of Receipt for Over-the-Counter Supplies:** We at Sole Foot & Ankle Specialists sell over the counter products for your foot care needs. If you decide to purchase our over the counter products, please be advised that they are nonrefundable.
**Initial:**_____

**Do we have permission to**: ☐ Leave a message on home answering machine? ☐ Leave a message at your job?
☐ Discuss your medical condition with any member of your household?
If so, Name_____ Relationship_____

**Emergency Contact:**_____ **Phone #**_____

**Appointment Cancellation Policy:** Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Patients will need to call 24 hours prior to the appointment time otherwise there will be a charge of $50.00 to the account. This “no-show charge” is not reimbursable by your insurance company. You will be billed directly for it.
**Initial:**_____

**Authorization and Consent to Photograph, Record, Publish**: It is our office policy to take photographs of part or all of the patients lower extremities. I authorize Sole Foot & Ankle Specialists to take and use photograph(s) of my condition for the purposes of, but not limited to, medical documentation, education, research, and scientific or public relations with the provision that my identity will remain confidential. **Initial:**_____

**Disclosure of Financial Interest:** I acknowledge I may receive services for medical care by my doctor. I understand my doctor may have financial interests for services provided to me by my practitioner. I understand that there are alternative options available should I decide not to utilize the services provided to me. I understand I have the option of using any other facilities of my choice. I understand that I will not be treated any differently if I chose to use another facility.
**Initial:**_____

**I understand that all co-pays, deductibles and co-insurance will be collected at the time of service. Initial:**_____

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES AND I ACCEPT THE RIGHTS AND RESPONSIBILITIES WITH THEM:

- **Patient Rights Regarding Medical Records**
- **HIPPA-Confidentiality and Privacy of Medical Records**
- **Patient Financial Responsibility**
- **Authorization to Photograph**

I hereby give permission to administer treatment and to perform such procedures as may be necessary in diagnosis and treatment. I also authorize the physician to release any all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company and there by authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

_____ _____
PATIENT NAME (print) DATE

_____ _____
PATIENT SIGNATURE NAME/RELATIONSHIP
(If signed by other than patient)

✻ Copies of each policy is available upon request.