FOOT & ANKLE INSTITUTE

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Account No._____

Patient's Name (First)_____(Initial) _____ (Last)_____

Mailing Address_____City_____State_____Zip_____

Physical Address_____City_____State_____Zip_____

Home Phone Number (_____)_____Cell Phone Number:(_____)_____

Date of Birth_____/_____/_____ Age_____ Sex: ☐Male ☐Female

Email Address:_____ Social Security No._____

Race: ☐Caucasian ☐Hispanic ☐African American/Black ☐Asian ☐American Indian ☐Other ☐Decline to answer
Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Decline to answer
Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Separated Employment: ☐full ☐part ☐self ☐retired ☐unemployed

Parent/Legal Guardian (if Patient is under 18)_____
Name Phone Number

Patient/Parent Employer_____Business Phone_____

Emergency Contact_____
Name Address Phone Number Relationship

Primary Care Physician:_____
Name Phone Number Month/Year of last visit

INSURANCE INFORMATION: Is patient covered under Medical Insurance? YES NO

Primary Insurance	Secondary Insurance
Ins. Name:	Ins. Name:
Policy #:	Policy #:
Subscriber's Name:	Subscriber's Name:
Subscriber's DOB:	Subscriber's DOB:
Subscriber's relationship to patient:	Subscriber's relationship to patient:

How did you hear about us? ☐ Radio ☐ Health & Wellness Mag ☐ Friend_____ ☐ Doctor_____

I hereby give Keith R. Reber, DPM, and/or S. Kent Burton, DPM, and/or Lary J. Smith, DPM, and/or Carl C. Van Gils, DPM, and/or Andrew B. Powell DPM, and/or Leon K Reber, DPM, and/or Brad S. Webb, DPM and/or, Ryan T. Peterson, and/or Shirl C. Cowley and/or South Main Surgery Center permission to examine and treat my lower limbs.

By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that a rebilling fee will accrue on all past-due balances at the amount of $5 per month until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

PATIENT'S SIGNATURE_____DATE_____

PARENT'S OR GUARDIAN'S SIGNATURE_____DATE_____

Patient's Name_____

PATIENT HISTORY

What is your foot problem?_____Duration of problem:_____
If injury, please give date, description and location of injury:_____
_____
Is this the first visit to a doctor for the problem?_____

ALLERGIES: Are you allergic to:

Adhesive ☐Yes ☐No	Morphine ☐Yes ☐No	Latex ☐Yes ☐No	Iodine ☐Yes ☐No
Aspirin ☐Yes ☐No	Sulfa Drugs ☐Yes ☐No	Codeine ☐Yes ☐No	Penicillin ☐Yes ☐No

Other, Please list:_____

FAMILY HISTORY:

Has anyone in your family (Mother, father, siblings, paternal/maternal grandparents, aunt, uncle etc.) had any of following? If so, who?
Arthritis:_____ Birth Defects:_____Cancer (what kind):_____
Diabetes:_____ Heart Attack:_____ High Blood Pressure:_____
Osteoporosis:_____ Stroke:_____

SOCIAL HISTORY:

Do you chew tobacco? ☐Never ☐Former ☐Everyday Do you use recreational drugs? ☐Yes ☐No
Do you smoke? ☐Never ☐Former ☐Everyday Do you drink alcohol? ☐Yes ☐No

SURGICAL HISTORY: Please list or attach all surgeries you have had along with approximate dates:

Type of Surgery Approx. Date Type of Surgery Approx. Date
_____
_____
_____

CURRENT MEDICATIONS:

(Please complete as much of the following information as possible, OR attach a list)

Name	Strength	Dosage/Frequency

Patient's Name_____

IMMUNIZATIONS:

Have you had a flu vaccine this flu season? □Yes □No If yes, Date:_____
If over age 65, have you had a pneumonia vaccine? □Yes □No If yes, Date: _____

DIABETES:

Are you Diabetic? □Yes □No If so, what type? □Type 1 □Type 2 Last A1c Value:_____
How you do you manage your diabetes? □Diet □Insulin □Oral Medication
Are you currently being treated for a kidney condition? □Yes □No
Doctor's Name and Phone #:_____
Have you have a Dilated Eye Exam within the last 12 months? □Yes □No
Eye Doctor's Name and Phone #:_____

REVIEW OF SYSTEMS/MEDICAL HISTORY:

Please circle/check the conditions for which you have been or are currently being treated for:

Respiratory: ○ Asthma ○ Pneumonia ○ Short of Breath ○ Emphysema	**Cardiovascular:** ○ Rheumatic Fever ○ Murmur ○ Heart Attack ○ Angina ○ Congestive Heart Failure ○ Hypotension ○ Hypertension	**Gastrointestinal:** ○ Hepatitis ○ Liver Dysfunction ○ Ulcers ○ Hiatal Hernia ○ Reflux ○ Diverticulitis ○ Diarrhea
Musculo-Skeletal: ○ Serious injuries or disorders of the Back ○ Deformities ○ Loss of Strength ○ Fibromyalgia ○ Joint Pains ○ History of Osteoarthritis or Rheumatoid arthritis	**Skin:** ○ History of MRSA ○ Lesions ○ Moles ○ Eczema ○ Rashes	**Neurologic:** ○ Weakness ○ Numbness ○ Strokes ○ Seizures ○ Migraines
Endocrine: ○ Diabetes ○ Hypoglycemia ○ Thyroid Dysfunctions	**Hematologic:** ○ Anemia ○ Bleeding Tendencies	**Genitourinary:** ○ Bladder Problems ○ Prostate problem ○ ESRD, CRF, ARF ○ Renal Insufficiency ○ Receiving Dialysis

Do you have any other condition or disease we should know about? _____

For Office Use Only:
Height_____Weight_____ Blood Pressure _____
If over 65, falls risk performed: □Yes □No