



# 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?

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  
 Do you drink alcohol? ..... Y N

If so, how many each day? \_\_\_\_\_ How long? \_\_\_\_\_ Quit? \_\_\_\_\_  
 If so, how much? \_\_\_\_\_ How often? \_\_\_\_\_