GLACIER FOOT & ANKLE ASSOCIATES

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	Marital Status:

Is this your legal name?	If not, what is your legal name?	Birth date:	Age:	Sex:
○ Yes ○ No		___/___/_____		○ M ○ F

Address:	City:	State:	Zip Code:

Social Security no.: _____-_____-_____	Home phone no.:	Cell phone no.:

Occupation:	Employer:	Employer phone no.:

Ethnicity:	Language:	Pharmacy:	Location:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	___/___/_____		

Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No

Please indicate PRIMARY INSURANCE:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:
	_____-_____-_____	___/___/_____		

Patient's relationship to subscriber:

Name of SECONDARY INSURANCE (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Subscriber's Date of Birth: ___/___/_____ Patient's relationship to subscriber:

EMERGENCY CONTACT INFORMATION

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

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/Guardian Signature Date

MEDICAL HEALTH & HISTORY

DESCRIBE PROBLEM

Right Foot:

Left Foot:

MEDICATION LIST

Name	Strength	Take How Often

MEDICAL HISTORY

Are you, or have you been treated for:

Y N	Diabetes- years_____ type_____	Y N	Hives
Y N	Gout	Y N	HIV-AIDS
Y N	Artificial Joints- type_____	Y N	High Blood Pressure
Y N	Anemia	Y N	High Cholesterol
Y N	Arthritis	Y N	Jaundice
Y N	Asthma	Y N	Kidney Trouble-type_____
Y N	Bleeding Problem	Y N	Liver Disease
Y N	Blood Clots, DVT, Phlebitis	Y N	Pacemaker
Y N	Bronchitis	Y N	Rheumatic Fever
Y N	Cancer- type_____	Y N	Scarring Tendency
Y N	COPD	Y N	Seizures
Y N	Dementia	Y N	Skin Rashes
Y N	Eczema	Y N	Sleep Apnea
Y N	Emphysema	Y N	Stomach Ulcers
Y N	Epilepsy	Y N	Thyroid Problem
Y N	Heart Problems- type_____	Y N	Venereal Disease
Y N	Heart Attack	Y N	Women- Are you Pregnant?
Y N	Artificial Heart Valve	Y N	Women- Are you Breastfeeding?
Y N	Hepatitis- type_____		Any other medical history not listed?

ALLERGIES

Allergy To (circle):	Reaction	Allergy To:	Reaction
Penicillin		Latex	
Sulfa Drugs		Sedatives	
Other Antibiotics		Local Anesthesia	
Codeine		Tape- Band Aids	
Aspirin		Iodine	
Anti-Inflammatory		Other:	

MEDICAL HEALTH & HISTORY

Current Weight_____ Height_____ Shoe Size_____

Primary Care Physician:_____ Date Last Seen:_____

Referring Provider:_____

SURGICAL HISTORY

Date	Surgery

FAMILY HISTORY

Who, in your family other than yourself, has been diagnosed with any of the following conditions?

Condition	Who
Heart Disease	
Diabetes	
High Blood Pressure	
Cancer- type_____	
Blood Clots	
Foot Problems	
Rheumatoid Arthritis	

SOCIAL HISTORY

Do You Smoke or Chew Tobacco? Y N If so, how many each day? _____ How Long? _____

Do You Drink Alcohol? Y N If so, how much? _____ How often? _____

History of Substance Abuse? Y N

Circle any current symptoms:

General:	Fever Chills Fatigue Unexplained Weight Loss Unexplained Weight Gain
Ear-Nose-Throat:	Discharge Nose Bleeds Difficulty Swallowing Swollen Glands
Endocrinology:	Excessive Thirst Excessive Urination Insomnia
Respiratory:	Shortness of Breath Chronic Cough Wheezing Phlegm
Cardiovascular:	Chest Pain Palpitations Ankle Swelling Murmur
Gastrointestinal:	Nausea Vomiting Heartburn Abdominal Pain Blood in Stool Diarrhea Constipation Yellow Runny Stool
Hematology:	Bleed Easily Bruising Swollen Glands Anemia
Genitourinary:	Kidney Stones Blood in Urine Painful Urination Incontinence
Musculoskeletal:	Joint Swelling Joint Pain Muscle Aches Back Pain Weakness
Skin:	Rash Itching Lumps/Growths Moles Lesions
Neurology:	Tingling Numbness Seizures Headaches Balance Issues
Psychiatry:	Depression Anxiety Suicidal Thoughts Substance Abuse

GLACIER
FOOT & ANKLE

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Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____ **Birth Date:**_____

☐ **PLEASE DO NOT SHARE MY MEDICAL INFORMATION WITH ANYONE.**

I HEREBY AUTHORIZE GLACIER FOOT & ANKLE ASSOCIATES TO SHARE: (Check all that apply)

- ☐ **All of my medical information**
- ☐ **My lab/radiology results**
- ☐ **My appointment times, dates, and reasons for visits**
- ☐ **The following information:** _____

WITH THE FOLLOWING PEOPLE:

Full Name:_____ Relationship: _____

Full Name:_____ Relationship: _____

Full Name:_____ Relationship: _____

Full Name:_____ Relationship: _____

I understand that I may cancel this consent at any time, but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want Glacier Foot & Ankle Associates to share my information with someone.

This authorization expires: ☐ When I cancel it in writing ☐_____
If no expiration date or event is specified, this authorization is effective until terminated by the patient.

Signature: _____ Date: _____

Relationship to minor patient (if parent or legal guardian): _____
If you are not the minor patient's parent, you must give us proof of guardianship (i.e. a court order or power of attorney).

Witness: _____ Date: _____