



Patient Information

Last name: _____ First name _____ Age _____ DOB ____/____/____
Sex M F Social Security # ____-____-____
Mailing Address: _____
City _____ State _____ Zip _____
Phone (check preferred) Cell _____ Home _____ Work _____
Email _____
Preferred contact method (please check) Text Call Email
Emergency Contact _____ Phone # _____ Relationship to patient: _____
If patient is a minor: Responsible Party's Name: _____ Relationship to Minor: _____
How did you hear about us? _____
Primary Care Physician: _____ Phone: _____
Persons authorized to access my medical information: _____

Insurance: Company _____ ID# _____ Group/Policy# _____
Name of Policy Holder _____ SS# ____-____-____ DOB _____
Is referral required? Yes No (patient responsible to obtain referrals)
Secondary Insurance ID _____ Group _____
Name of Policy Holder _____ SS# ____-____-____ Relationship to patient _____

Today's Problem

Describe today's problem(s): _____
How long have you had the problem: _____
Rate the pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10
What makes the problem worse: _____
What makes the problem better: _____
What have you tried to treat the problem: _____
Please mark the location of today's problem(s):

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

Allergies/Sensitivities: _____

Current medications/supplements (or provide us with a **complete** copy of your current medications):

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

Preferred Pharmacy: _____ **Location:** _____

Medical History – Please indicate if you, personally, have experienced any of the following:

No major illness or other prior medical conditions

Cardiovascular

__ Peripheral Artery Disease
__ Peripheral Vein Disease
__ High Blood Pressure
__ High Cholesterol
__ Atrial Fibrillation/Arrhythmia
__ Heart Attack
__ Coronary Artery Disease
__ Congestive Heart Failure
__ Stroke/TIA
__ Other: _____

Kidney

__ Kidney Disease
__ Kidney Failure
__ Kidney Infection
__ Kidney Stone
__ Other: _____

Genitourinary

__ Recurrent Urinary Tract Infections
__ Prostate Enlargement
__ Prostate Cancer
__ Other: _____

Immune

__ HIV
__ Chronic Skin Infection
__ MRSA
__ Hepatitis A B C
__ C. Difficile
__ Other: _____

Respiratory

__ Asthma
__ Bronchitis
__ COPD
__ Emphysema
__ Other: _____

Liver/Gall Bladder

__ Cirrhosis
__ Gall stones
__ Other: _____

Endocrine

__ Prediabetes
__ Diabetes (insulin dependent)
__ Diabetes (non-insulin dependent)
__ Chronic steroid use
__ Adrenal Disease
__ Thyroid Disease
__ Other: _____

Rheumatology

__ Rheumatoid Arthritis
__ Sjogren's Syndrome
__ Raynaud's Syndrome
__ Ehlers Danlos
__ Seronegative Arthropathy
__ Other: _____

Musculoskeletal

__ Fibromyalgia
__ Back/Neck Pain
__ Osteoporosis/Osteopenia

Gastrointestinal

__ Reflux/Heartburn
__ Crohn's Disease
__ Ulcerative Colitis
__ Irritable Bowel Syndrome
__ Bleeding Ulcers
__ Other: _____

Dermatology

__ Melanoma
__ Squamous Cell Carcinoma
__ Basal Cell Carcinoma
__ Other: _____

Nervous/Psychiatric

__ Seizure Disorder
__ Multiple Sclerosis
__ Parkinson's Disease
__ Depression/Anxiety
__ Peripheral Neuropathy
__ Other: _____

Hematologic

__ Bleeding Disorder
__ Clotting Disorder
__ Platelet Disorder
__ DVT/Blood Clots
__ Other: _____

__ Osteoarthritis

__ Gout
__ Cysts
__ Other: _____

Other medical conditions not listed above: _____

Cancer history, including type: _____

List any prior complications with anesthesia: _____

Are you pregnant? __ Yes __ No

Are you nursing? __ Yes __ No

Surgical History – Please list ALL surgeries you have had:

Surgery:	Year:	Surgery:	Year:
_____	_____	_____	_____
_____	_____	_____	_____

Family History – Please check any known health conditions in your family:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Amputation | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Diabetes Type 2 |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Stroke | | | |
- Other: _____

Social History

Tobacco Use: _____ Never _____ Year quit _____ Current Packs per day: _____

Alcohol Use: _____ Never _____ Year quit _____ Current Amount/frequency: _____

Drug Use: _____ Never _____ Year quit _____ Current Type: _____

Occupation: _____

Marital Status: Single Married Separated Divorced Widowed

Please provide any other pertinent information: _____

Medical Information Release

I acknowledge that I have been offered a copy of the NOTICE OF PRIVACY POLICY of **Treasure Valley Foot and Ankle** (“TVFA”) and that TVFA may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker’s compensation carriers. I further acknowledge that TVFA may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize TVFA to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, film/images, and other clinic information deemed necessary by TVFA physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with TVFA’s privacy policy.

Consent for Treatment

I hereby consent to the medical treatment, diagnostic, and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). TVFA will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Financial Responsibility and Agreement

I hereby authorize any benefits due me to be paid directly to Treasure Valley Foot and Ankle. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, co-pay or non-covered services or services deemed as “non-medically necessary” by my third party insurance carrier which could include orthotics, braces, splints, over-the-counter medications, heel cups, pads, toe separators, etc. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits, including obtaining a valid referral from my primary care physician, if necessary. I authorize TVFA to send a claim/bill to my insurance directly and receive payment for services provided. All delinquent accounts will be charged an interest rate of 1.5% per month 18% per annum. In the event any balance is not paid as agreed, I agree to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, I further agree to pay court costs and reasonable attorney fees. I agree, to permit TVFA to service my account or to collect any amounts I may owe, and to contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. TVFA may also contact me by sending text messages or e-mails, using any email address I provide to them. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable. In consideration for medical services rendered, I acknowledge that I have access to TVFA’s financial policy and agree to pay for said medical services according to such terms. To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect 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.

Patient/Responsible Party Signature: _____ Date: _____