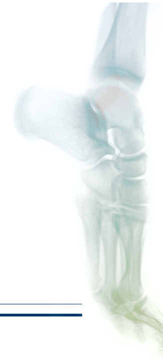
CONFIDENTIAL
PATIENT HEALTH RECORD



ADVANCED FOOT & ANKLE CLINIC

12201 Pecos Street Suite 400
Westminster, CO 80234
office: 303.469.9292 fax: 303.438.8951

Today's Date:________________ How did you hear about us? ____________________________

Patient Name:______________________________ Date of Birth:________________

Street Address:________________________ City:____________ State:______ Zip:______

Home Phone:________________________ Cell Phone: ________________________

Work Phone:________________________ Email Address: ________________________

Sex: ☐ Male ☐ Female Social Security No.________________________

Employer:________________________ Occupation:________________________

Marital Status (circle one): Single Married Divorced Separated Widowed

If applicable:

Name of Spouse: ________________________ Spouse's Employer:________________________

Spouse's Work Phone:________________________

Name and Phone Number of Emergency Contact: ________________________

☐ I give Advanced Foot & Ankle Clinic permission to leave x-ray, lab results, prescriptions and other medical information with/at: ____

RESPONSIBLE PARTY: (Primary Insurance Holder)

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other:____________

Name:______________________________ Date of Birth:________________

Street Address:________________________ City:____________ State:______ Zip:______

Home Phone:________________________ Cell Phone: ________________________

Work Phone:________________________ Email Address: ________________________

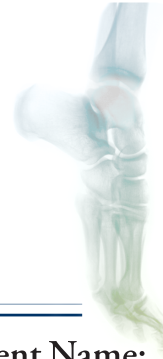
Sex: ☐ Male ☐ Female Social Security No.________________________

Employer:________________________ Occupation:________________________

CONSENT FOR MEDICAL TREATMENT I, the undersigned patient, having come to Advanced Foot and Ankle Clinic voluntarily to obtain medical advice and treatment, give my informed consent to be evaluated and treated by the medical doctors and staff of Advanced Foot and Ankle Clinic. This includes all verbal discussions, physical examinations, and medical procedures that may be deemed necessary by my care providers. I can, at any time, withdraw my consent for specific procedures after discussion with my care providers.

Patient Name:______________________________ Date:________________

Signature:________________________ Relationship to patient: ☐ Self ☐ Parent ☐ Guardian



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MEDICAL HISTORY

Patient Name:___________________________

Name of Primary Physician (PHP):_________________________________ Phone: ___________________________

Height:___________________________ Weight:_______________________ ShoeSize:___________________________

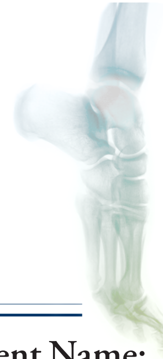
Do you have or have you ever had...

(please check all that apply)

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Anxiety
- ☐ Alcohol Dependency
- ☐ Back Pain
- ☐ Bleeding Disorders
- ☐ Blood Clots
- ☐ Bronchitis
- ☐ Cancer
  Type:____________________
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Cirrhosis
- ☐ COPD
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Depression
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Elevated Cholesterol
- ☐ Fainting
- ☐ Foot or Leg Cramps
- ☐ Foot Ulcer
- ☐ Gout
- ☐ Glaucoma
- ☐ Gallbladder Disease
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hypothyroidism
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hemophilia
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Migraines
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ STD
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Sinus Infection
- ☐ Swelling in Feet/Legs
- ☐ Urinary Tract Infection
- ☐ Tuberculosis
- ☐ Varicose Veins

Check any of the following you or your relatives have had:

	Arthritis	Osteoporosis	Cancer	Diabetes	Heart Trouble	Stroke	Anxiety	Bleeding Disorders
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐
Spouse	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐	☐



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MEDICAL HISTORY (cont'd)

Patient Name:_______________________

Please list any prescription medications you are currently taking or have taken in the last year:

Medication Name	Diagnosis

Please list any over-the-counter medications you are currently taking, include vitamins, herbals, supplements:

Product	Symptom	Quantity and Frequency

Are you allergic to any of the following (please check all that apply):

☐ Adhesive tape ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa

Other Drug Allergies: ____

Food/Animals: ____

Please list all the surgical procedures you have had:

Procedure	Date of Procedure

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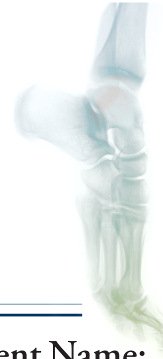


MEDICAL HISTORY (cont'd)

Patient Name:_______________________

Please describe any hospitalizations you have had in the past 20 years, include date and diagnosis:

____

____

____

____

____

Date of last Tetanus Vaccination:_______________________________

Tobacco Use: # of years smoked _______________ Packs per Day ________Quit Date ___________

Alcohol Use: # of glasses per week _______________ Type Consumed_______________________

Substance use:

Name of Substance(s)_______________________ Last Date of Use ____________________

Do you drink caffeine? ☐ Yes ☐ No If yes, how much per day? ____________________________

CURRENT HEALTH CONDITION

Overall Health (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is the reason you are here? _______________________________________

____

____

Have you seen other physicians for this condition? ☐ Yes ☐ No

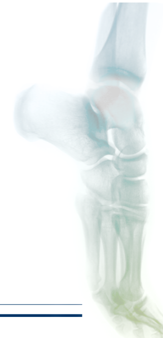
Name of Physician _______________________ Type of Treatment _____________________

Results: ____

____

When did this condition begin? _______________________________________

Has this condition occurred before? ☐ Yes ☐ No Do you wear orthotics? ☐ Yes ☐ No



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PAYMENT TERMS & AGREEMENTS

I, the undersigned, in consideration for services rendered to me by Advanced Foot & Ankle Clinic (AFAC), understand and agree to the following:

1. Any copayments are required to be paid on the day of service are rendered.
2. Payment for charges is due on the date of service with the exception of insurance carriers for which AFAC is under contract to file directly. If I receive a ill for those services not covered by my insurance company, I will pay for these, charges within 15 days of the statement date. Accounts not paid in full within 60 days will be sent to collections.
3. In case of default payment, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs.
4. My insurance may not pay for all charges incurred in obtaining treatment. I will be responsible for any copayment, deductible, coinsurance, or any service not covered by my insurance for services rendered. I agree to pay all charges resulting from such services. If I do not have insurance I agree to pay for all charges resulting from services on the same day of service.
5. Referrals must be obtained and presented at office visit if required. It is my responsibility to make sure referrals are obtained if needed. It is also my responsibility to make sure any services provided are covered by my insurance. It is my responsibility to make sure AFAC is in network with my insurance company.
6. A current insurance card must be presented at each office visit. It is my responsibility to notify the office of any and all insurance changes. Failure to notify the office to these changes will make me responsible for claims not accepted by the insurance company.
7. I, hereby authorize AFAC to file with my insurance carrier, and I assign payment of medical benefits to AFAC and in addition, I authorize the release of any and all records and information necessary to process any claim generated by services I receive.
8. I have been given a copy of Advanced Foot & Ankle Clinic Privacy Practices.
9. Orthotics are custom inserts that are made especially for me. If my insurance denies payment it is my responsibility to pay for these orthotics. Once orthotics have been ordered, I understand that I am fully responsible for payment.

I have read and agree to the above Payment Terms and Agreements:

_______________________________ _______________________________

Signature of patient (or responsible party) Date