ADVANCED FOOT & ANKLE CENTER PC
OF MT

Bruce D. Fisher, DPM

REGISTRATION FORM Date:_____

Patients Name: _____ Maiden/Previous Name: _____

Mailing Address: _____ City/St: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Employer: _____ Spouse's Employer: _____

Date of Birth: _____ Sex: M or F Marital Status: M S D W

Age: _____ SS#: _____ Referring Doctor/Person: _____

Primary Care Physician: _____ Date of last visit to primary: _____

Primary Pharmacy : _____ City: _____

Ethnicity/Race: White, American Indian/Alaska Native, Asian, African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander, Middle Eastern, Two or more races, or Prefer not to answer.

Preferred language: English, Spanish, German, French, Other:_____ prefer not to answer.

If patient is a minor or in the care of other adult/guardian:

Guardian Name _____ Relationship: _____

Person responsible for charges: _____ SS# _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone No: _____

Do You Have a Disability? *YES / NO If yes, what is the nature of your disability?* _____

Are you currently in a PAIN MANAGEMENT contract? YES / NO If not answered truthfully, it is grounds for immediate patient termination.

Do You Have Health Insurance? *YES / NO If yes, please provide a copy to the receptionist. If no, you will need to pay for your visit at the time of service unless other arrangements have been made.*

Is this a Workman's Compensation Case? *YES / NO If so, this visit must be approved in advance!*

Who is policyholder of your insurance? SELF _____ OTHER (NAME) _____

If 'other' please provide the person's date of birth _____ Relationship _____

Employer: _____ If TRICARE, provide the sponsor No: _____

1016 9th Street South • Great Falls, MT 59405
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COMPREHENSIVE HISTORY - PAST, SOCIAL & FAMILY HISTORY

Name: _____ DOB: _____ Today's Date: _____

Please describe your current foot problem(s):	**Latex Allergy?** Yes / No (please circle)
	List any ALLERGIES to medications:
If injury, where & when did it occur:	

How long have you had this problem? Onset: ☐Sudden ☐Gradual	Were you previously treated? ☐Yes ☐No If yes, by whom?

Please circle any of the following CURRENT foot concerns:

Burning Coldness Cramping Numbness Pain Swelling Weakness Dryness

Redness Itchiness Fungal Nails Athlete's Foot Excessive Sweating - or - NONE

Please list PAST foot and ankle issues/injuries/surgeries: _____

Past Medical History: Please check "Yes" or "No" box ***if you have*** any of the following illnesses:

	Yes	No	Explain		Yes	No	Explain
Diabetes				Neurological problems			
Hypertension (HBP)				Stroke			
Thyroid problems				Seizure			
Heart disease/attack				Hepatitis			
Lung problems				Gout			
Bleeding disorder				Cancer			
Stomach/intestinal problems				HIV			
Kidney problems/stones				Other med. Diagnosis			
Fibromyalgia							
Mental illness							

Please list current medications (including aspirin, anti-inflamatories, allergy meds):

Please List any operations and dates of operations you have had:

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

	Yes	No	Please list details below:
Do you smoke? List how much.	☐	☐	
If no, did you smoke previously?	☐	☐	
How often do you drink alcohol?			
History of drug addiction?	☐	☐	
What is your occupation?			

Family History:

	Yes	No	Father	Mother	Siblings	Grandparents
Diabetes	☐	☐	☐	☐	☐	☐
Heart problems/murmurs	☐	☐	☐	☐	☐	☐
Anesthesia problems	☐	☐	☐	☐	☐	☐
Allergy	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐

COMPREHENSIVE HISTORY & PHYSICAL
REVIEW OF SYSTEMS

Today's Date:_____ Height:_____ Weight:_____ Shoe Size:_____

Name: _____ DOB: _____

	YES	NO	CURRENT		YES	NO	CURRENT
CONSTITUTIONAL							
Chills	☐	☐	☐	Weight loss or gain	☐	☐	☐
Fatigue	☐	☐	☐	Daytime sleepiness	☐	☐	☐
ALLERGY							
Environmental	☐	☐	☐	Sneezing fits	☐	☐	☐
NEURO							
Headache	☐	☐	☐	Tremors	☐	☐	☐
Lightheaded/Dizzy	☐	☐	☐	Paralysis	☐	☐	☐
Passing out	☐	☐	☐	Weakness	☐	☐	☐
Convulsions/Seizures	☐	☐	☐	Numbness/Tingling	☐	☐	☐
EYES							
Wear glasses/Contacts	☐	☐	☐	Blurred vision	☐	☐	☐
Eye pain / pressure	☐	☐	☐				
ENT							
Hearing loss	☐	☐	☐	Throat pain	☐	☐	☐
RESPIRATORY							
Cough	☐	☐	☐	Coughing blood	☐	☐	☐
Wheezing	☐	☐	☐	Shortness of breath	☐	☐	☐
CARDIAC							
Chest pain	☐	☐	☐	Palpitations	☐	☐	☐
Wake short of breath	☐	☐	☐	ankle swelling	☐	☐	☐
GI							
Abdominal pain	☐	☐	☐	Heartburn	☐	☐	☐
Bowel irregularity	☐	☐	☐	Nausea / vomiting	☐	☐	☐
GU							
Frequent urination	☐	☐	☐	Pregnancy	☐	☐	☐
Painful urination	☐	☐	☐	Blood in Urine	☐	☐	☐
HEME/LYMPH							
Swollen glands	☐	☐	☐	Night sweats	☐	☐	☐
Bleeding problems	☐	☐	☐	Easy bruising	☐	☐	☐
MUSCULOSKELETAL							
Joint aches/pain	☐	☐	☐	Muscle aches	☐	☐	☐
Joint stiffness	☐	☐	☐	Muscle/joint weakness	☐	☐	☐
Difficulty walking	☐	☐	☐	Back pain	☐	☐	☐
Muscle pain and/or cramps	☐	☐	☐	Cold extremities	☐	☐	☐
PSYCH							
Depression	☐	☐	☐	Anxiety or panic	☐	☐	☐
Nervousness	☐	☐	☐	Sleep problems	☐	☐	☐

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Payment Policy

1. Billing Insurance: It will be out pleasure to bill your insurance company for you provided that you submit accurate billing information.

2. Co-Pays: Co-pays are expected at the time of service with no exceptions. It is your contractual agreement with your insurance to pay your co-pay at the time of service.

3. Coverage Change: If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be automatically billed to you with payment expected within 30 days.

4. Payment: We accept payment of cash, check, credit or debit cards.

5. Payment Plan: If your entire balance is not paid within three billing cycles/months, a $35.00 administrative charge will be added to your account and interest will begin to accrue at this time at a rate of 15% per annum.

6. Nonpayment: If your account is over 90 days past due and/or you have broken a payment agreement with us, your account will be forwarded to a collection agency. This may result in garnishment of wages and/or other legal actions. You will be responsible for any collection fees incurred and you and your immediate family members may be discharged from this practice.

7. Policy Changes: This policy is effective beginning November, 2009, and we reserve the right to revise as necessary.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____Signat
ure of patient or legal guardian Date

In addition, I acknowledge I have received the Notice of Privacy Practices, have had an opportunity to review it and permit a copy of this authorization to be used in place of its original.

I am also aware that if I miss two or more scheduled appointments without prior cancellation or notification to this office that I will not be permitted to schedule any further appointments unless otherwise agreed.

_____
Signature of patient or legal guardian

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