Ritchie Steed, DPM·Flatirons Foot & Ankle Clinic·630 Coffman St. Suite A·Longmont·CO·80501
(303) 772-7008
www.flatironsfoot.com

*****PLEASE PRINT CLEARLY*****

***Name**_____

Nickname _____ Social Security Number _____

***Birthdate**:_____ Age_____

***Gender**: F ( ) M ( )

Address_____

City _____State _____*Zip_____ Home phone ( ) _____

Cell Phone ( ) _____ Email: _____

Ethnicity: O Not Recorded/Choose not to report O Hispanic or Latino O **NOT** Hispanic or Latino

Primary Language: O English O Spanish O Other:_____

Race: OChoose not to report OAmerican Indian or Alaska Native OAsian OBlack or African American ONative Hawaiian/ Pacific Islander OWhite

Marital Status: OSingle OMarried OWidowed ODivorced OOther

Currently Employed: O Yes O No Occupation Current or Former:_____

Employed by: _____Work Phone ( ) _____

Person responsible for bill: _____Social Security _____

Birthdate: _____ Phone: (if different from above) _____

Address (if different from above) _____

Insurance Policy Holder: _____ Birthdate: _____

Relationship to patient: _____

Address if different from above: _____

Preferred Pharmacy: _____
Emergency Contact: _____ Phone: _____

Personal Physician's Name: _____Phone: _____

How did you find out about our office? ODoctor OInternet ODexKnows OFriend OPhone Book OOther

Who can we thank for referring you? Name_____

Contact Preference: O by phone: o patient only, o patient and/or spouse, o anyone answering the phone
O by mail
O by email

By providing your Email, you are consenting to receive information from our online <u>Patient Portal and Electronic Reminders System</u>. If you wish to OPT OUT of this system, please inform a member of our staff.

**Please know that we make every effort to keep your information private and do not share it without your consent. We are a near paperless medical office. All forms including this one that you fill out will be scanned electronically and placed in your electronic chart and then the paper forms will be shredded and destroyed.

I have read the above statement and consent to the conversion of my paper forms to electronic forms in my electronic chart at Flatirons Foot & Ankle Clinic.

_____
Signature of patient/guardian date

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*****PLEASE PRINT CLEARLY*****

Name: _____

Reason for Today's Visit: _____

Allergies: ☐ Penicillin ☐ Aspirin ☐ Novocain ☐ Band-Aid/Tape ☐ Codeine ☐ Iodine ☐ Shellfish ☐ Latex ☐ Sulfa ☐ None Other Allergies: _____

Current medications, pills, vitamins: or- ☐ None

_____

_____

Immunizations up to date and Tetanus within the last 10 years? ☐ Yes ☐ No ☐ Not Sure

Date of Last Physical?_____

PLEASE CHECK IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

__ Heart Murmur	__ Anemia	__ Acid Reflux	__ Kidney problems
__ Heart Attack	__Raynaud's disease	__ Gout	__ Thick scars
__ Rheumatic Fever	__Diabetes	__ Cancer	__ Poor healing
__ Heart Pacemaker	__Peripheral Neuropathy	__Arthritis	__ Bruise easily
__ Peripheral Vascular Disease	__ Foot Ulcers/Wounds	__ Dizziness	__ Lack of feeling
__ High Blood Pressure	__ Psoriasis	__ Chills, nausea, night sweats	__ Psychiatric care
__ Stroke	__ Seizures	__ Artificial Heart Valve	__ Lung disease
__ Tuberculosis	__Depression	__ Circulation problems	__ Liver disease
__Hepatitis	__ Back Pain	__Stomach problems	

*Other health problems: _____

Past Surgeries: _____

_____

Do you use tobacco in any form? __ Yes __ No Number of packs or cigars/day_____ x _____ years

If you have used tobacco in the last 24 months, have you received treatment or information to stop? ___Yes ___No

Current Smoker____ Former Smoker____ Never Smoker____

Do you drink alcoholic beverages? __ Yes __ No Number of drinks/week_____

Family History: Mother: ___ Diabetes ___ Heart Attack ___Heart disease ___High blood pressure ___High Cholesterol ___Circulation problems ___Foot problems

Father: ___ Diabetes ___ Heart Attack ___Heart disease ___High blood pressure ___High Cholesterol ___Circulation problems ___Foot problems

Family History Other:_____

Shoe Size: _____ Height_____ Weight_____

WOMEN ONLY: Are you pregnant? __ Yes __ No **Past Pregnancies?** ___Yes ____ No How Many? ____

☐ To help Dr. Steed in my medical care, I give consent to the sharing of my medical information with my primary care doctor.

_____

Patient/Parent/Guardian signature date

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Acknowledgments and Financial Policy

1. The patient and insurance information is correct to the best of my knowledge. It is my responsibility to notify Flatirons Foot & Ankle Clinic of any changes.

2. I understand that insurance coverage is not a guarantee of payment from my insurance company and that I am financially responsible for all services rendered. In instances of insurance plans where Dr. Steed is a non-participating provider all charges will be paid for at the time of service. **PLEASE NOTE: We do NOT accept Medicaid.**

3. I understand that co-payment is due at the time of service and any charges that are billed to me are to be paid in full 10 days from the statement date unless other arrangements have been made with the Office Manager. If arrangements are not made with the Office Manager finance charges will be applied as outlined in item #7.

4. I understand that if I do not make monthly payments on my pre-arranged payment plan by the date due, payment in full will be expected.

5. I authorize the release of any information, including medical information, which is necessary to secure payment or process insurance claims.

6. A photocopy of this authorization is to be considered as valid as the original.

7. I understand that if I do not pay all charges and late fees by the 30 day time limit, after issued a final notice, my account will be sent to a collection agency. I will be liable for a reasonable collection agency fee that is 35 % of the unpaid principle balance. These fees will include all court costs, attorney fees, and collection agency fees. Finance charges of 15% will be added to the unpaid balance each month the account is not paid full.

Initials

8. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read, if I so choose, and understand the Notice.

I have read and understood this document.

Patient Name (please print) Date

Parent or Authorized Representative (if applicable)

Signature Date