Teton Foot and Ankle Center

Welcome To Our Office

Patient Information

Patient Account # Date Social Security #

Name (Last, First, M.I.) Date of Birth Gender Marital Status
M / F M / S / D / W

Mailing Address City State Zip

Home Phone Cell Phone

Place of Employment Work Phone

Parent / Person Responsible for Account Responsible Person's Date of Birth

Mailing Address City State Zip

Home Phone Cell Phone

Patient Info: Race ☐ African American ☐ Native American ☐ Caucasian ☐ Asian ☐ Mexican ☐ Other__________

Ethnicity ☐ Hispanic/Latino ☐ Mexican ☐ Pacific Islander ☐ Other_____________
____

Primary Insurance Information

Primary Insurance Company Address Co-Pay Amount

ID # Group #

Policyholder Name Date of Birth Social Security #

Secondary Insurance Information

Primary Insurance Company Address Co-Pay Amount

ID # Group #

Policyholder Name Date of Birth Social Security #

Office Policy: Your co-pays, deductibles or percentages are due at the time of service. We file insurance claims on your behalf. However, you are responsible for all deductibles and charges not covered by insurance. Please keep us informed of all changes to your coverage. All collection costs and attorney fees are your responsibility if not paid as agreed. I have read the above and accept financial responsibility for this account.

Authorization: By signing this, I authorize release of any/all medical records regarding my care to another physician/facility. I understand that this medical information may be used for Diagnostic, Insurance, Legal and other reasons as deemed necessary by Teton Foot and Ankle Center to ensure the best medical care on my behalf.

Signature X____ Date____________________________

Minor Patients Only

I authorize Teton Foot and Ankle Center to treat minor patients when NOT accompanied by parent or legal guardian.

Signature X____ Date ___________________________

Emergency Contact Information (Person not living with you) Phone
( )

Medical Information

Patient Age

What current foot / ankle problem has brought you to our office today?____
____

Referring / Current Physician
First Name Last Name MD / DO /PA / NP Office Phone #
( )

Pharmacy Name and Location:

Medications Please list all prescription and over-the-counter medications you are currently taking (including herbal):
____
____
____

Allergies: (Please check all known allergies you may have.)				
	☐ ADHESIVE TAPE	☐ NOVOCAINE	☐ EGGS	☐ OTHER________________________
	☐ LOCAL ANESTHETICS	☐ CODEINE	☐ SHELLFISH	☐ OTHER________________________
	☐ METALS	☐ PENICILLIN	☐ LATEX	☐ OTHER________________________
	☐ SOYBEANS	☐ SULFA	☐ ASPIRIN	

General Medical History:

☐ AIDS/HIV	☐ TB	☐ SWELLING, FOOT, CHRONIC	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ VARICOSE VEINS	☐ ULCERS, SKIN	☐ STROKE
☐ ARTHRITIS/RHEUMATOID	☐ ALLERGY TO ANESTHETICS	☐ VENEREAL DISEASE	☐ SWELLING, LEG(S), CHRONIC
☐ ARTHRITIS/OSTEOARTHRITIS	☐ MRSA	☐ ASTHMA	☐ ULCERS, STOMACH
☐ BACK PROBLEMS	☐ ARTIFICIAL HEART VALVE	☐ CANCER	☐ WEIGHT LOSS, UNEXPLAINED
☐ CHEMICAL DEPENDENCY	☐ BLEEDING DISORDERS	☐ CIRCULATION PROBLEMS	
☐ DIABETES	☐ CHEST PAIN	☐ EPILEPSY	
☐ FAINTING	☐ DIARRHEA, CHRONIC	☐ GOUT	SMOKER:
☐ HEADACHES, CHRONIC	☐ FOOT CRAMPS	☐ HEMOPHILIA	☐ YES
☐ HEPATITIS	☐ HEART DISEASE	☐ KIDNEY PROBLEMS	☐ NO
☐ LEG CRAMPS	☐ HIGH BLOOD PRESSURE	☐ LOW BLOOD PRESSURE	☐ NEVER
☐ NERVOUS PROBLEMS	☐ LIVER DISEASE		
☐ RADIATION TREATMENT	☐ PHLEBITIS		
☐ RHEUMATIC FEVER	☐ RASH, CHRONIC		
☐ SWELLING, ANKLE(S), CHRONIC	☐ SHORTNESS OF BREATH		
	☐ PSYCHIATRIC DISORDERS		

List any surgeries and hospitalizations you have had (both major and minor): ____
____
____
____

Consent: I certify that the above information is true and correct to the best of my knowledge.
I give my permission for Dr. Michael K. James to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and /or treatment of my foot and/or ankle problems.

X____ Date__________________________________