PIKES PEAK
FOOT & ANKLE CLINIC

Dr. Matthew Thomas DPM
2620 Tenderfoot Hill St Ste 200
Colorado Springs, CO 80906
(719) 867-8838

PATIENT REGISTRATION INFORMATION

NAME(LAST, FIRST):_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
DATE OF BIRTH:____ /_____/_____GENDER (CIRCLE ONE): M F
SS#_____PHONE: HOME:_____CELL:_____
E-MAIL*(we will not share this information)*:_____

Referred by (Physician or Patient) NAME:_____
How did you find out about us? GOOGLE BING YELP INSURANCE OTHER_____

EMERGENCY CONTACT:
NAME (LAST, FIRST) _____Relationship:_____
Phone: Home_____Cell_____

YOUR EMPLOYMENT INFORMATION:
COMPANY:_____PHONE:_____
ADDRESS:_____

INSURED PERSON (IF SOMEONE OTHER THAN PATIENT:
NAME (LAST,FIRST): _____RELATIONSHIP:_____
ADDRESS:_____PHONE:_____
DOB:___/____/____ SSN#_____

DISCLOSURE OF PATIENT PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home. Please circle your preferred method of contact:

HOME WORK CELL E-MAIl

NAME OF PREFERRED PHARMACY:_____
PHONE:_____ADDRESS:_____
CITY:_____STATE:_____ZIP_____

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PIKES PEAK FOOT AND ANKLE CLINIC OFFICE POLICIES

In order to continue to serve our valued patients we have adpoted the following policies:

1: CANCELLATIONS: We require at least a 24 hour notice for cancellation of appointments so that we may offer your appointment time to another patient. If you do not provide at least a 24 hour notice, you will receive a bill for the **$40 no-show fee.**

2: TARDINESS: If you are 15 minutes late or more, you may be rescheduled in order to accommodate our other patients' appointment slots.

3:MEDICAL RECORDS: We are happy to fax your medical records to other physicians at no charge. If a paper copy is requested there will be a **$30 charge.**

I have read and understand the policies set by Pikes Peak Foot And Ankle Clinic and agree to the terms.

*Signature:*_____ *Date:*_____

PRACTICE POLICIES

Private insurance authorization for assignment of benefits and release

I, the undersigned, authorize payment of medical benefits to PIKES PEAK FOOT AND ANKLE CLINIC for any services furnished to me or my child by the physician. I understand that I am financially responsible for any amount not covered by my insurance policy. I also authorize PIKES PEAK FOOT AND ANKLE CLINIC to release to my insurance company, referring physician, or any other consultants on my case, information concerning healthcare, advice, treatment, or supplies provided to me. The information will be used for the purpose of evaluating and administering claims of benefits.

*Signature:*_____ *Date:*_____

Health Insurance Portability and Acountability Act: By initialing this document, I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES OF PIKES PEAK FOOT AND ANKLE CLINIC.

Initials_____

Financial Policy: By initialing this document, I acknowledge that I have been given the opportunity to read, and agree to the terms outlined in the financial policy of Pikes Peak Foot and Ankle Clinic.

Initials_____

Photograph Authorization: I hereby authorize Pikes Peak Foot and Ankle Clinic to take photos for inclusion in the medical chart retained by the clinic. I understand this photograph will be used for the purpose of identification and familiarization by the office staff, clinical physicians, and consulting physicians. Clinical Xrays, or other images may be utilized for research, educational, or marketing purposes, with protection of patient identifying information.

Initials_____

*Signature:*_____ *Date:*_____

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Medical History

PLEASE FILL OUT THIS FORM COMPLETELY AND PLACE N/A IF NOT APPLICABLE TO YOU

NAME:_____DATE OF BIRTH:____/_____/____

Describe your current foot/ankle problem:_____

_____

How long have you had this problem:____Days_____Weeks_____Months_____Years

Have you tried treating this yourself? If Yes How?_____

_____

Family Physician:_____Last Visit Date:_____/_____/____

Allergies: (Please Circle any Allergies) NONE

Adhesive Tape Codine Iodine Local Anesthetics Penicillin Sulfa NSAID's

Other:_____

Family Medical History: Please list any significant family medical history)_____

_____

Smoking History: ( ) Never Smoked. ( ) Past Smoker ( ) Current smoker #/Day_____

Alcohol Use: ( ) No ( ) Yes. How many/how often:_____

Previous Surgeries: (Please list procedure and dates)_____

_____

_____

Height:_____ **Weight:**_____ **Shoe Size:**_____

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Please Check YES or NO to indicate if you have any of the following

	Y	N		Y	N		Y	N		Y	N
Aids/HIV			**Circulatory problems**			**Hepatitis**			**Radiation treatment**		
Allergies to anesthetics			**Depression**			**High blood pressure**			**Respiratory disease**		
Anemia			**Diabetes**			**Jaundice**			**Rheumatic fever**		
Angina			**Dialysis**			**Kidney problems**			**Rheumatoid arthritis**		
Arthritis			**Ear problems**			**Liver disease**			**Sinus problems**		
Artificial heart valves			**Epilepsy**			**Low blood pressure**			**Skin cancer**		
Artificial joints			**Eye problems**			**Nervous problems**			**Stroke**		
Asthma			**Fainting**			**Neuropathy**			**Swollen neck glands**		
Back problems			**Glaucoma**			**Osteoporosis**			**Thyroid problems**		
Bleeding disorders			**Gout**			**Phlebitis**			**Tuberculosis**		
Cancer,			**Heart attack**			**Pneumonia**			**Ulcers**		
Cataracts			**Heart disease**			**Prostate problems**			**Varicose veins**		
Chemical dependency			**Heart surgery**			**Psoriasis**			**Venereal disease**		
Chronic diarrhea			**Hemophilia**			**Psychiatric care**			**Other,**		

Medications: (Please list current medications including over-the-counter medications, such as vitamins, supplements, and oral contraceptives

_____

_____

_____

_____

_____

Consent: I attest that the information I provided regarding my medical history is true and correct, to the best of my knowledge. I give permission to the Dr to administer any treatment or procedure that may be deemed necessary in this and subsequent visits.

*Signature*_____*Date:*_____