MISSOULA
FOOT & ANKLE GROUP

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# ACKNOWLEDGEMENT OF RECEIPT
# OF
# NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name Date

_____

Parent or authorized representative (if applicable)

_____

Patient signature

MISSOULA

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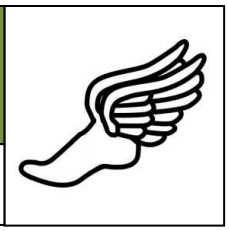

# PATIENT INFORMATION SHEET (PLEASE PRINT)

**NAME** _____
LAST FIRST MIDDLE

**DATE OF BIRTH:** _____ **AGE:** _____ **SEX:** _____ **SS#:** _____-____-_____

**MAILING ADDRESS:** _____
STREET CITY STATE ZIP

**PHYSICAL ADDRESS (IF DIFFERENT):** _____

**HOME PHONE:** _____ **CELL PHONE:** _____ **E-MAIL:** _____

**MARITAL STATUS (CIRCLE):** SINGLE MARRIED DIVORCED WIDOWED

**EMPLOYER INFORMATION:**
EMPLOYER NAME: _____ ADDRESS: _____
WORK PHONE: _____

**EMERGENCY CONTACT:**
CONTACT PERSON: _____ PHONE #: _____ RELATION: _____

**PRIMARY CARE PHYSICIAN:** _____

**WHO WERE YOU REFERRED BY?** _____

**PARENT OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT):**

NAME: _____ DOB: _____ AGE: _____ SEX: _____

ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE: _____ WORK PHONE: _____

RELATIONSHIP TO PATIENT: _____

**INSURANCE INFORMATION (INSURANCE CARDS ARE REQUIRED ON-HAND FOR THE FIRST VISIT):**

**PRIMARY INSURANCE NAME:** _____ **SECONDARY:** _____
**INSURANCE ID#:** _____ **INSURANCE ID#:** _____
**GROUP #:** _____ **GROUP #:** _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary for the processing of insurance claims, insurance applications, and prescriptions. I do also authorize the payment of medical benefits to the phsyician who is rendering care.

**PATIENT OR RESPONSIBLE PARTY SIGNATURE:** _____ **DATE:** _____

**MISSOULA FOOT AND ANKLE GROUP: HEALTH HISTORY (CONFIDENTIAL)**

Patient Name: _____ Date of Birth: ____/____/_____ Age: _____
Height: _____ Weight: _____ Shoe Size _____ Married/Single: _____ Sex: _____
Occupation: _____ Does your job allow light duty? Yes No
Primary Care Physician: _____ Date last seen: _____
Other physicians seen: _____

What is your reason for today's visit? _____
Which side is affected? _____ When did the symptoms first appear? _____
Please list symptoms: _____
Have you tried any other treatment prior to today? _____

Allergies: _____
Current Medications (give a copy of medication list if you have one)_____
_____

Have you received any of the following diagnoses (circle):

| | | | |
|---|---|---|---|
| **Diabetes** | **High Blood Pressure** | **Heart Disease** | **Heart Attack** |
| **Stroke** | **High Cholesterol** | **Heart Failure** | **Circulatory problems** |
| **Varicose veins** | **Asthma** | **COPD/Emphysema** | **Hypothyroidism** |
| **Epilepsy** | **Spine or Nerve problems** | **Muscle weakness/spacticity** | **Fibromyalgia** |
| **Osteoarthritis** | **Rheumatoid arthritis** | **Gout** | **Lupus** |
| **Anemia** | **Hemophilia** | **HIV+** | **Hepatitis B/C** |
| **Acid reflux** | **Crohn's disease** | **Ulcerative colitis** | **Enlarged prostate** |
| **Bladder dysfunction** | **Uterine fibroids** | **Cancer survivor? (give type): _____** | |
| **Anxiety** | **Depression** | **Bipolar disorder** | **Schizophrenia** |

Any other diagnoses not listed above: _____
Are you possibly pregnant?: Yes NO
Do you smoke? Yes No How many packs/day?_____ How many years? _____
Do you drink alcohol? Yes No How many drinks/weeks? _____
Any history of prescription or illicit drug abuse? Yes No Were you treated? _____
Please list any surgeries you have had and approximate date: _____
_____
Any medical problems run in your family? (parents/siblings): _____
_____

Have you had any of the following symptoms in the last months (circle):

| | | | | | | |
|---|---|---|---|---|---|---|
| **Fever** | **Chills** | **Nausea** | **Vomiting** | **Diarrhea** | **Headache** | **Dizziness** |
| **Tingling** | **Numbness** | **Burning** | **Weakness** | **Lethargy** | **Dyscoordination** | |
| **Cramping** | **Cold toes** | **Rashes** | **Itching** | **Dry skin** | **Fatigue in legs when walking** | |

Do you use any kind of assistive device? (braces, cane, wheelchair, etc.): _____
What kind of shoes do you normally wear?: _____

Signature of patient or legal guardian Date