Kalispell Foot & Ankle Clinic
907 S Main Street
Kalispell, MT 59901
(406)755-5250

Please take a moment to review, making sure all fields are accurate and correct.

Patient Name_____

Date of Birth_____ Social Security Number_____

Mailing Address_____

City/State/Zip_____

Home Phone_____ Ok to leave message? Yes No Brief Extended

Cell Phone_____ Ok to leave message? Yes No Brief Extended

Work Phone_____ OK to leave message? Yes No Brief Extended

Do we have permission to discuss your medical condition with any member of your household? Yes No

If yes, whom_____ Relationship to you_____ Phone #_____

If yes, whom_____ Relationship to you_____ Phone #_____

Primary Care Doctor_____ Date of last visit w/Primary Care Doctor_____

Primary Insurance_____ Subscriber Name & Date of Birth_____

Secondary Insurance_____ Subscriber Name & Date of Birth_____

Minor Patient's Responsible Party_____

Were you referred to our office by: Doctor Friend Phone Book Other_____

****

I understand this office is in compliance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996. This is to keep my protected health information private. I understand that the office HIPPA policy is available to me upon request. I permit release of information concerning dates of treatment, condition, diagnosis or procedures to my personal physician, referring physician and/or the referring facility or for follow-up care. My signature below authorizes the release of any medical information necessary to process claims and request that payment of all assigned benefits be made to the provider of services. I understand that I am financially responsible for non-covered benefits, deductibles and co-payments at the time of service. Should the account be referred to a collection agent, the undersigned shall pay all collection expenses.

_____

Date Patient Name Signature of Patient/Responsible Party

Medical History

Patient's height_____ Patient's Weight_____

Briefly describe your current foot problem_____

_____

Please circle any of the following conditions you now have or have had previously:

Heart Disease	Circulation Problems	Diabetes	Breathing/Lung Problems
Cancer	Arthritis	Anemia	High Blood Pressure
Blood Clots	Gout	Stroke	Thyroid

Other_____

Does your family have any history of the following conditions? (please circle)

Heart Disease	Diabetes	Stroke	Hammertoes
Bunions	Flat Feet		

Please list any medications you are presently taking_____

_____

Please list any Medication Allergies you have _____

_____

My signature acknowledges the above is correct to the best of my knowledge.

_____

Date Patient Signature