

Save Your Sole Foot & Ankle Specialists

1927 Wilmington Dr., Suite 102
Fort Collins, CO 80528
(970) 416-9009 Fax (970) 416-9010

1220 W. Ash St., Suite A
Windsor, CO 80550
(970) 416-9009

Personal Information

Name: _____ Birth date: _____ Today's date: _____

Billing Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cellular phone: _____

Email address: _____

Preferred method of appointment reminders: Email Text Phone

Ethnicity: African American / Asian American / Caucasian / Hispanic / Native American /

Pacific Islander (Hawaiian) / Other: _____

Preferred spoken language: _____

Age: _____ SS# last 4 digits: _____ Sex: M / F Occupation: _____

Employer: _____ Work phone: _____

Preferred pharmacy: _____ Location: _____

Primary family physician: _____

How did you hear of our clinic? _____

Marriage status (circle): Single Married Widowed Divorced Other

Emergency contact (list parent if minor): Name _____

Relationship: _____ Phone number: _____

Today, my foot/ankle complaint is: 1. _____

(if time allows) 2. _____

The condition(s) has existed for (how long)? _____

Is this related to a specific injury? _____ Date of injury? _____

Have you had this problem before? _____ How long ago? _____

Previous treatment(s)? _____

Allergic to latex? Yes No What reactions do you get if "yes"? _____

Height: _____ **Weight:** _____ **Shoe Size:** _____ **Wears custom orthotics?** _____

Review of Systems: (check all that applies)

____ In general good health ____ Recent significant weight gain ____ Recent significant weight loss

Eyes: ____ Does not apply ____ Wear glasses/contact lenses ____ Cataracts ____ Glaucoma ____ Macular degeneration

Ears/Nose/Mouth/Throat: ____ Does not apply ____ Sinusitis ____ Swollen lymph nodes
____ Difficulty hearing ____ Using hearing aids ____ Others (please describe)

Cardiovascular: ____ Does not apply ____ History of heart attack ____ DVT ____ High blood pressure
____ History of stroke ____ Heart murmurs ____ High Cholesterol ____ Others (please describe)

Gastrointestinal: ____ Does not apply ____ History of stomach ulcer ____ IBS ____ Heartburn/reflux
____ Hiatal hernia ____ Hepatitis (A/B/C) ____ Cirrhosis ____ Others (please describe)

Genitourinary: ____ Does not apply ____ Kidney stones ____ Benign prostate hypertrophy (in men)
____ Overactive bladder ____ Frequent UTI ____ Others (please describe)

Please turn over →

Pulmonary: ___ Does not apply ___ COPD ___ Emphysema ___ Asthma ___ History of pulmonary embolism

Musculoskeletal: ___ Does not apply ___ Rheumatoid arthritis ___ Psoriatic arthritis ___ Osteoporosis ___ Osteopenia ___ Lower back pain/arthritis/herniated disc/pinch nerve ___ Sciatica ___ History of chronic ankle sprains ___ Osteoarthritis(where? _____) ___ Ehlers-Danlos syndrome _____ Others (describe) _____

Skin: ___ Does not apply ___ Eczema ___ History of Athlete's foot _____ Others (describe) _____

Neurological: ___ Does not apply ___ Migraine headache ___ Numbness of hands ___ Seizures ___ Numbness of feet ___ Multiple sclerosis ___ Charcot-Marie-Tooth disease

Psychiatric: ___ Does not apply ___ Depression ___ Anxiety ___ Bipolar disorder ___ ADHD _____ Others (describe) _____

Endocrine: ___ Does not apply ___ Gout ___ Type 1 Diabetes ___ Type 2 Diabetes ___ Thyroid problems _____ Others(describe) _____

Hematologic: ___ Does not apply ___ Bleeding disorder ___ Anemia _____ Others(describe) _____

Allergic/Immunologic: ___ Does not apply ___ Auto-immune disease ___ HIV positive

What operations or surgeries have you had? _____

___ **Yes** ___ **No** Do you smoke tobacco? If **yes**, how much? _____ Smoking how long? _____
If **no**, did you smoke in the past? _____ When did you quit? _____

___ **Yes** ___ **No** Do you use recreational drugs? If **yes**, how much? _____ Using how long? _____
If **no**, did you use in the past? _____ When did you quit? _____

___ **Yes** ___ **No** Do you drink alcohol? How much do you drink? _____

___ **Yes** ___ **No** Do you exercise on a regular basis? If yes, please describe. _____

Does anything significant run in your family? (i.e. heart disease, diabetes, foot deformities) Please list all conditions. _____

If there's anything else in your medical history that may be important for your physician to know in order to facilitate your treatment? Please describe: _____

RELEASE OF MEDICAL INFORMATION

I authorize Save Your Sole Foot and Ankle Specialists to release and obtain medical information as required for my treatment and processing of my insurance claim. I realize that it is my responsibility to pay for any services rendered. A monthly billing charge will be added to all accounts over sixty days. I understand if any balance is unpaid after 60 days, it will be sent to collections. I will also be responsible for the cost of collections, plus attorney and court fees, which may amount to 50% of the original owed amount.

I request that payment of authorized insurance or Medicare benefits be made on my behalf to Save Your Sole Foot and Ankle Specialists for the services rendered to me.

I authorize Save Your Sole Foot and Ankle Specialists to release any information needed to determine these benefits or the benefits payable for related services.

I authorize release of medical information to my primary care physician or other specialty physicians related to my treatment.

Signature: _____ Date: _____