

**Dr. Michael I. Thomas, DPM**

DATE OF APPOINTMENT OR UPDATE \_\_\_\_\_

**PATIENT INFORMATION** (please print, fill out all sections completely – you will be asked to fill in any blank sections)

LEGAL NAME (first) \_\_\_\_\_ (last) \_\_\_\_\_ (M.I.)  Female  Male  
 Married  Single  Divorced  Widowed  Child (under 18) NICK NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_ (required for unique identification) PHONE ( ) \_\_\_\_\_  
CELL PHONE #( ) \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER (School, if student) \_\_\_\_\_

WORK PHONE # ( ) \_\_\_\_\_  Full-time  Part-time  Retired (if retired, Name of Company) \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

NAME, ADDRESS & PHONE # OF FAMILY DR. \_\_\_\_\_

\_\_\_\_\_ FOR MEDICARE PATIENTS: EXACT DATE OF LAST VISIT: \_\_\_\_\_

**How did you hear about us? Provide name, address and phone so we may send a thank-you!**

Relative \_\_\_\_\_

Friend \_\_\_\_\_

Doctor \_\_\_\_\_

Internet (check one):  Search  Dex Online  Website  Other: \_\_\_\_\_

Yellow Pages (which one) \_\_\_\_\_ Newspaper (which one) \_\_\_\_\_

Coupon (Type) \_\_\_\_\_  Mailer (Type) \_\_\_\_\_ Other (please specify) \_\_\_\_\_

**Family Information**  Spouse  Parent/Guardian  Other (specify) \_\_\_\_\_

Name \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

Name & Phone # of closest person not living with you to contact in case of emergency \_\_\_\_\_

**Payment Information** \*Please fill in info below and hand your card to receptionist. A copy will go in your medical record.

**Primary Insurance Name** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Name of policyholder** \_\_\_\_\_ **ID #** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Policyholder's SS #** \_\_\_\_\_ **Policyholder's Birthdate** \_\_\_\_\_

**Patient's relationship to policyholder:**  Self  Spouse  Child  Other (please specify) \_\_\_\_\_

**Secondary Insurance Name** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Name of policyholder:** \_\_\_\_\_ **ID #** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Policyholder's SS #** \_\_\_\_\_ **Policyholder's Birthdate** \_\_\_\_\_

**Patient's relationship to policyholder:**  Self  Spouse  Child  Other (please specify) \_\_\_\_\_

**Is this a work related injury?**  Y  N If yes, date of injury \_\_\_\_\_

**Is your injury related to an auto accident?**  Y  N If yes, date of accident \_\_\_\_\_

**Please explain how your injury happened, if not work or accident related:** \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

## **PAST MEDICAL HISTORY**

### **Major Illnesses:**

- Diabetes       Heart Disease       High Blood Pressure       Chest Pain       Cancer  
 Heart Attack       Mitral Valve Prolapse       Murmur       Arrhythmia       Stroke       HIV

Please Explain: \_\_\_\_\_

### **Respiratory:**

- Asthma (Last Attack/Regular Inhaler Use)       Bronchitis       Emphysema       Frequent Colds  
 Sinus Problems or Infections       Shortness of Breath       Lung Disease       Pneumonia       Tuberculosis

Please Explain: \_\_\_\_\_

### **Head/Ears/Eyes/Nose/Throat:**

- Tonsillitis or Throat Infections       Glaucoma Eye or Vision Problems       Regular Headaches  
 Migraine Headaches       Ear Infections       Hearing Deficit

Please Explain: \_\_\_\_\_

### **Gastro-Intestinal:**

- Ulcers       Acid Reflux (GERD)       Hiatal Hernia       Stomach Disorder       Bowel Disorder  
 Irritable Bowel Syndrome       GI or Rectal Bleeding

Please Explain: \_\_\_\_\_

### **Genito-Urinary:**

- Kidney or Bladder Infections       Kidney Stones       Prostate Disease       Venereal Disease

Please Explain: \_\_\_\_\_

### **Vascular Disease/Blood Disorders:**

- Anemia       Sickle Cell       Bleeding Disorders       Poor Circulation       PVD  
 Leg Pain when Walking       Night Cramps       Excessive Bleeding following surgery  
**Vein Problems**       Swelling       Spider Veins       Varicose Veins       Leg Ulcers  
**Clotting Disorders**       Blood Clots       Arms       Legs       Lungs       Phlebitis

Color Changes of Skin When Cold / Reynaud's Syndrome

Please Explain: \_\_\_\_\_

### **Arthritis:**

- Joint Implants       Rheumatoid Arthritis       Osteoarthritis       Gout       Other

Please Explain: \_\_\_\_\_

### **Skin Disorders:**

- Keloids or Thick Scar Formation       Psoriasis       Skin Cancer

Please Explain: \_\_\_\_\_

### **Psychological:**

- Anxiety       Depression       History of Drug or Alcohol Dependency

Please Explain: \_\_\_\_\_

### **Pain Syndromes:**

- Reflex Sympathetic Dystrophy       Fibromyalgia       Chronic Pains

Please Explain: \_\_\_\_\_

### **Misc Illnesses:**

- Epilepsy or Seizures       Thyroid Disease       Muscle Disease       Hepatitis       HIV / AIDS

Please Explain: \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

## Medical History

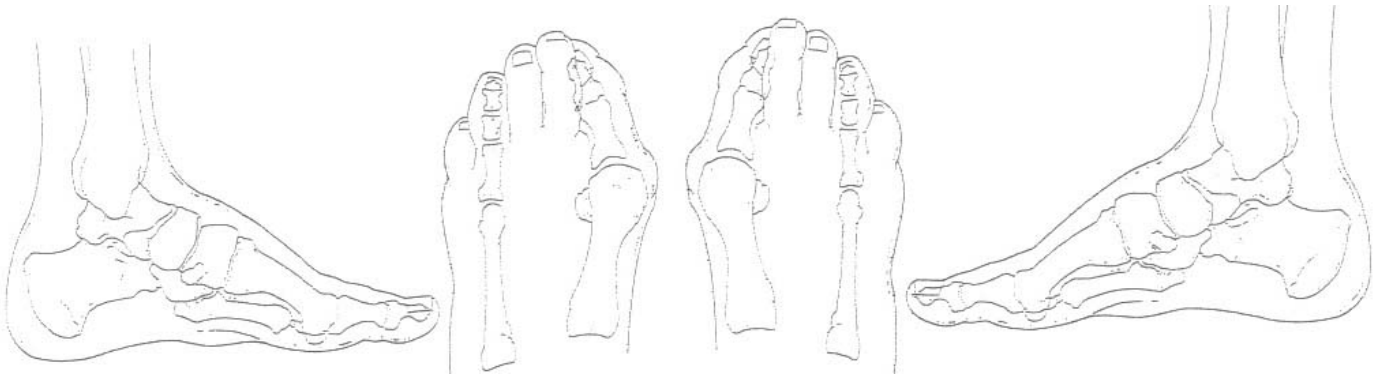
### Chief Complaint(s)/Reason for Coming to the Clinic:

\_\_\_\_\_  
\_\_\_\_\_

How long has this been a problem? \_\_\_\_\_

Prior home/professional treatment (orthotics, injections, surgery, etc.) \_\_\_\_\_

### Circles areas of concern:



**Vitals:**                      **B/P:** \_\_\_\_\_                      **Pulse:** \_\_\_\_\_                      **Temp:** \_\_\_\_\_

**Allergies:**                       No Known Drug Allergies

### Please state Reactions:

- |  |   |
|--|---|
| <input type="checkbox"/> <b>Penicillin:</b> _____<br><input type="checkbox"/> <b>Codeine:</b> _____<br><input type="checkbox"/> <b>Latex:</b> _____<br><input type="checkbox"/> <b>Local Anesthetics:</b> _____<br><input type="checkbox"/> <b>Metals / Earrings / Jewelry:</b> _____<br><input type="checkbox"/> <b>Other Medications:</b> _____<br><input type="checkbox"/> <b>Food Allergies :</b> _____<br><input type="checkbox"/> <b>Environmental Allergies :</b> _____<br><input type="checkbox"/> <b>Other:</b> _____ | <input type="checkbox"/> <b>Sulfa Drugs</b> _____<br><input type="checkbox"/> <b>Iodine / Shellfish</b> _____<br><input type="checkbox"/> <b>Aspirin:</b> _____<br><input type="checkbox"/> <b>General Anesthetics:</b> _____ |
|--|---|

### Medications:

\_\_\_\_\_  
\_\_\_\_\_

- Echinacea     Garlic     Ginger     Ginko Biloba     St. John's Wort     Ginseng     Ephedra  
 Kava Kava     Valerian     Other Diet Pills: \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Previous Surgery:** ( Type / Date)

\_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations / injuries:**

\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Do you use Tobacco? Y/N Did you Smoke? Y/N Yrs. Quit \_\_\_\_\_ How Much? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink Alcohol? Y/N Did you Drink? Y/N Estimate # of drinks per day/week/month? \_\_\_\_\_

Occupation: \_\_\_\_\_ Physical / Athletic Activities \_\_\_\_\_

**Family History:**

Any family members with anesthesia difficulties? \_\_\_\_\_

Diabetes: \_\_\_\_\_

Other: \_\_\_\_\_

**Vital Statistics:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Are you pregnant? Y/N Could you be pregnant? Y/N Are you nursing? Y/N

**PERMISSION / RELEASE OF INFORMATION:**

1. I HEREBY GIVE MY PERMISSION TO Dr. James Anderson, Dr. Michael Thomas, and Dr. Jared Overman to administer, with my permission, treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of the extremity condition.
2. I also hereby assign to the above named physician all benefits provided to my insurance company policy or policies for medical or surgical care.
3. I authorize my consent to Poudre Valley Foot & Ankle Clinic, PC to call and remind me of upcoming appointments or to make follow-up calls after treatment.

Signature of Patient: \_\_\_\_\_

Signature of Parent / Guardian: \_\_\_\_\_

**POUDRE VALLEY FOOT AND ANKLE CLINIC, PC (PVFAC)  
NOTICE OF PRIVACY PRACTICES**

This notice describes how your health information may be used, disclosed and how you can access this information. Please review it carefully.

At the Poudre Valley Foot and Ankle Clinic, PC we have always kept your health information secure and confidential. We take precautions to secure electronic information. Firewalls and passwords are in place. A new law requires that we continue to maintain your privacy, give you this notice and follow the terms of this notice.

The law permits our clinic to use or disclose your health information to those involved with your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company in order to be reimbursed for services.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. The PVFAC has a written contract with each business associate that requires them to protect your privacy.

We may use information to contact you. For example, we may send newsletters or other information to the address you have provided us with. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

With the exceptions as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you to the requested office.

You have the right to see and receive a copy of your health information, with a few exceptions you will be required to give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. You will be required to make the requested changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add the new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy and Security Officer at (970) 484-4620.

This notice goes into effect as of April 14, 2003.

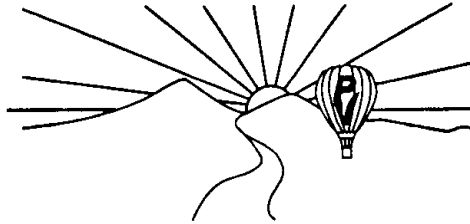
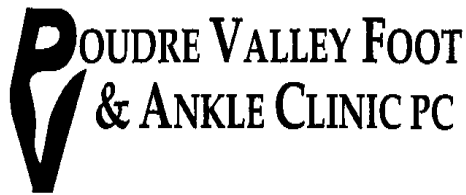
**Acknowledgement**

I have read the above and I am aware that a copy of the Poudre Valley Foot and Ankle Clinic, PC Notice of Privacy Practices is available per my request.

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

If signing as a parent or guardian, please note the name of the patient: \_\_\_\_\_

Date: \_\_\_\_\_



**Dr. James C. Anderson, DPM**  
Certified: American Board of Podiatric Surgery  
Member, American College of Foot and Ankle Surgeons  
Fellow: American College of Podiatric Sports Medicine

**Dr. Michael I. Thomas, DPM**  
Certified: American Board of Podiatric Surgery  
Member, American College of Foot and Ankle Surgeons

**Dr. Jared L. Overman, DPM**  
Member, American College of Foot and Ankle Surgeons  
Qualified: American Board of Podiatric Surgery

## **Financial Policy**

Thank you for choosing our practice! We are committed to providing you with quality podiatric care. We have developed this payment policy to assist you in understanding our financial practices. Please read it carefully and sign in the space provided.

### **Insurance**

We participate with many insurance plans, including Medicare. If you are not insured by a plan we do business with or you do not have insurance, payment in full is expected at each visit. Your insurance benefit is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility. Please contact your insurance carrier with questions regarding your coverage.

If you have insurance coverage, you must present a valid insurance card at each visit. We will keep a copy of the most recent insurance card in your medical record. If your insurance coverage changes, you must notify us as soon as possible to avoid delay in your claims processing. If you fail to inform us of updated insurance, balance on unpaid claims will become your responsibility. Co-payments and deductibles must be paid for at the time of service. This is part of your contract with your insurance company.

### **Non-Covered Services**

Please be aware that some of the services you receive may be non-covered by your insurance carrier. These services must be paid for at time of visit.

### **Claims Submission**

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

### **Payment**

For your convenience, we accept cash, checks, VISA, MasterCard, American Express, Discover, and Care Credit. We reserve the right to refer your account to a collection agency if your account is over 90 days past due.

Thank you for understanding our payment policy. Please let us know if you have any questions. ***I have read and understand the payment policy and agree to abide by its guidelines:***

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Signature

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Date