Patient Information

Range Foot and Ankle
Dr Katie Evans

Name_____ M / F

Address_____

City_____State____ Zip _____

Phone_____

Work/Cell_____

Email_____

Birth Date_____/_____/_____

Social Security_____

Employer_____

Employer's Phone_____

Pharmacy_____

How did you hear about our office?

_____

Marital Status:

Single / Married / Widowed / Divorced / Separated

Emergency Contact:

Name_____

Relationship_____

Phone #_____

Preference for any messages such as appointment reminders, lab results, etc. left with people or an answering devices.

_____OK to leave a message:

_____Myself _____Spouse _____Other____

_____anyone answering phone

_____do NOT leave message

Revised 08/07/2018

I consent to all medical care, examinations, and tests determined to be necessary for me. Though I expect the care given to meet customary standards, I understand that there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me. I will not hold Range Foot and Ankle or any individual responsible for any of the consequences. I understand that I am being established by Range Foot and Ankle as a recurring patient to be provided a series of ongoing services based on my provider's orders.

I give permission to Range Foot and Ankle to take photographs for medical and/or teaching purposes. No personal identifications will be revealed.

I hereby acknowledge that I have been offered a copy of the Range Foot and Ankle Notice of Privacy Practices.

ASSIGNMENT OF BENEFITS: I hereby assign all medical benefits to which I am entitled to Range Foot and Ankle. This applies for all insurance carriers, including Medicare, private insurances and any other health/medical plans. This form will be kept on file. I understand that it is my responsibility to report any changes in insurance coverage. I also understand that it is my responsibility to know my insurance policy, and I am fully responsible in obtaining any referrals that may be required **PRIOR** to my appointment with Range Foot and Ankle. I understand that if a required referral is not obtained, I will take full responsibility in the payment for any unpaid fees. I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for the continued medical care. I understand that I am financially responsible for any amount not covered by insurance and any past due accounts are subject to collection proceedings.

I have read all of the above and agree.

Patient Signature_____

Date_____/_____/_____

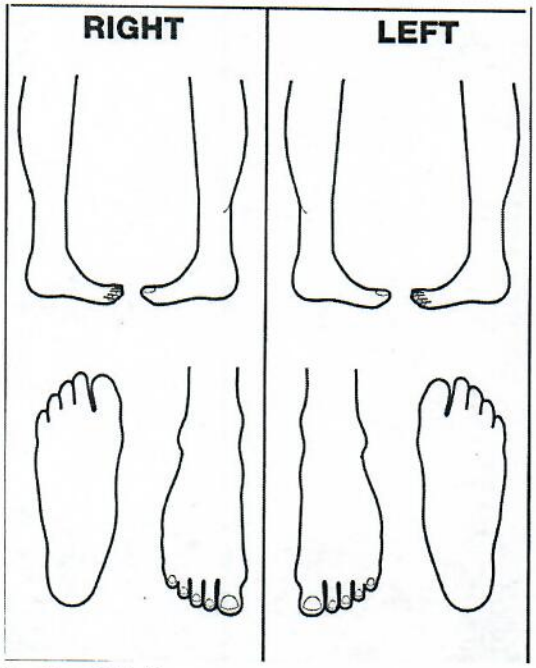
616 9th Street North, Virginia MN
218-749-3818

Range Foot and Ankle **Dr. Katie Evans**

MEDICAL HISTORY

Name:_____ Date:_____

Podiatric History:



Complaint:_____

Please indicate the area of your pain or problem on the foot diagrams to the left.

Duration of problem:_____

Was it caused by an injury? ___Yes ___No
If yes, was it a work-related injury? ___Yes ___No

Do you have an Advanced Care Directive? YES or NO

If yes, you can provide us with a copy if you feel we should have one on record for you. If you do not have one, but would like to have one, let us know and we can help you get one.

Medical History:

Diabetes __Type 1 __Type 2 last A1C result_____ & Date (Approx.) _____

Please Provide us with a copy of your most recent A1C report for our records.

Complications: __Neuropathy (nerve) __Retinopathy (eyes) ___Renal (kidney) __PVD / PAD (circulation)

Tobacco History: __Never __Quit /Year? _____ Type: __cigarettes __cigar __pipe __chew

Alcohol Use: __Daily __Weekly __Monthly __Rarely __None

Do you receive regular vaccinations such as the flu or pneumonia vaccines? Yes No

Drug Allergies (with reactions):_____

_____

_____

Revised 08/07/2018

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Range Foot and Ankle **Dr. Katie Evans**

Are you currently, or have you ever been treated for or taken medication for any of the following?

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint _____
- ☐ Back Problems
- ☐ Cancer: Type_____
- ☐ Chemical/Drug Dependency:_____
- ☐ Epilepsy
- ☐ Seizure disorders
- ☐ Vertigo
- ☐ Fibromyalgia
- ☐ Gout
- ☐ GERD
- ☐ Stomach Ulcers
- ☐ Blood Clots: Location_____
- ☐ Blood Pressure
- ☐ Varicose Veins
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Other:_____

- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ Angina or other chest pains
- ☐ Stroke / TIA
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Lung Disease: COPD / Asthma /_____
- ☐ Neuropathy (nerve)
- ☐ Depression
- ☐ Anxiety
- ☐ Other Psychiatric History:_____
- ☐ Migraines
- ☐ Severe Rash
- ☐ Thyroid: High or Low
- ☐ Tuberculosis
- ☐ Ulcer / Wounds
- ☐ Unexplained weight loss or gain
- ☐ Vision Problems_____
- ☐ Other:_____

Family Physician or clinic: _____Last Visit Date: _____

If you have been under any other doctor's care for any reason over the past two years please explain reason:

_____

_____

Please list all surgeries you have had in the past and the approximate dates performed _____

_____

_____

_____

_____

Please indicate below any family medical history below each person.

MOTHER:
Diabetes
Cancer
Heart Attack
Heart Disease
High Blood Pressure
Stroke
Rheumatoid Arthritis
Gout
Other: _____

FATHER:
Diabetes
Cancer
Heart Attack
Heart Disease
High Blood Pressure
Stroke
Rheumatoid Arthritis
Gout
Other: _____

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Range Foot & Ankle

MEDICATIONS

Name_____ Date_____

Medication	Dose	Frequency

Appointment Cancellation/No Show Policy

Our goal is to provide quality individualized medical care in a timely manner. "No Shows" and late cancellations inconvenience those individuals who are in need of medical treatment. We would like to remind you of our office policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please call us promptly at 218-749-3818 if you need to cancel or reschedule yor appointment. We require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the opportunity to receive our care in a timely manner.

As a courtesy, our staff will call you in advance to confirm your appointment. We will leave a voice mail message if we are unable to reach you personally. If you are unable to keep your appointment, we will be happy to cancel or reschedule it for you.

No Show Policy

A "No Show" is someone who is not present at the time of their scheduled appointment and has not provided adequate notification. We understand that emergencies may occur, however, when you do not call to cancel an appointment, you are preventing another patient from getting much needed treatment.

Charge for Late Cancellations or No Show's

After your 3rd "No Show" or late cancellation, you will receive a non-refundable administrative charge of $50, billable to YOU and NOT covered by your insurance company, each time a late cancellation or "No Show" occurs.

If you have any questions or concerns regarding this policy, please ask our staff and we will be glad to clarify for you. We thank you in advance for your cooperation and understanding.