RED ROCKS FOOT & ANKLE CENTER, PLLC

Patient Information

Name: ______________________ Date: ______________________

Address: ____

______________________ Phone (W) ______________________

Phone (H) ______________________ Phone (C) ______________________

Date of Birth: ______________________ Social Security Number: ______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Your Occupation: ______________________ Your Employer: ______________________

Person responsible for payment of medical bills, if not Patient: ______________________

INJURY: ☐ YES ☐ NO Date of Injury: ______________________

Nature of Injury: ____

Insurance Information

Insured Name: ______________________ Social Security Number: ______________________

Insured's Employer: ____

Primary InsurnaceCO. ______________ Subs.# __________ Group# __________ Member# __________

Secondary InsurnaceCO. ______________ Subs.# __________ Group# __________ Member# __________

Work.Comp. Claim #______________________ Adjuster Name&Phone#: ______________________

Assignment

I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance.

Date: ______________________ Signature: ______________________

Release

I hereby authorize the physician to release any information required to my insurance company.

Date: ______________________ Signature: ______________________

Phone: 303-797-6001 • Fax: 303-797-7452

RED ROCKS FOOT & ANKLE CENTER PLLC

Patient Health History

Name: ________________________________ Gender: _____ Age: _____ DOB: _______________

Email: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ @ ____________________

Height: ______ Weight: _______ Activities/Sports: ____

Primary Care Physician: ________________________________ Date: __________________________

Please describe the nature of the FOOT/ANKLE Problem: _____________________________________

____

____

Please list all MEDICATIONS you are currently taking: _______________________________________

____

ALLERGIES to MEDICATIONS and REACTIONS:____

ALLERGIES to FOOD and MATERIAL: ____

Previous Surgeries: ____

____

Please check any of the following MEDICAL CONDITIONS that you have or had:

☐ Anemia	☐ High Blood Pressure	☐ Phlebitis	☐ AIDS/HIV
☐ Arthritis	☐ Low Blood Pressure	☐ Cancer	☐ Depression
☐ Asthma	☐ Kidney disease	☐ Hepatitis	☐ Dementia
☐ Diabetes	☐ Bleeding Tendency	☐ Convulsions	☐ Heart Disease
☐ Gout	☐ Respiratory Problems	☐ Stomach Problems	☐ High Cholesterol
☐ Hypothyroidism	☐ Skin Condition	☐ Healing Problems	☐ Osteoporosis

☐ Autoimmune Disorder ☐ Other Illnesses not listed: ________________________________

Family History of Specific Illnesses: ____

____

Do you smoke?	YES	NO	Packs per day: ____________________
Do you drink Alcohol?	YES	NO	Drinks per week: ____________________

REVIEW of SYSTEMS

Please circle Yes or No to indicate if you currently have any problems in one or more of the following areas? If yes, please explain or describe the problem.

*GENERAL / CONSTITUTIONAL (fever, weight loss or gain, tired feeling) YES NO

____

*EYES (blurred vision, eye pain, discharge, etc) YES NO

____

*EARS, NOSE, THROAT, MOUTH (hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc.) YES NO

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*RESPIRATORY (asthma, emphysema, chronic bronchitis, wheezing, shortness of breath, etc.) YES NO

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*CARDIOVASCULAR (hypertension, heart problems) YES NO

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*GASTROINTENSTINAL (diarrhea, constipation, hernia, ulcers, etc.) YES NO

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*GENITOURINARY (painful urination, frequent urination, impotence, etc.) YES NO

____

*LYMPHATIC (anemia, bleeding problems, problems with blood transfusions, etc.) YES NO

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*ENDOCRINOLOGY (hypothyroidism, diabetes mellitus) YES NO

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*MUSCULOSKELETAL (arthritis, joint pain, swelling, cramps, stiffness) YES NO

____

*SKIN (pimples, warts, growths, rashes, etc.) YES NO

____

Who may we thank for referring you to our office? ____

Patient Signature: ______________________________