Mountain View Foot & Ankle Institute

DAVID B. GLOVER, DPM, FACFAS

PATIENT INFORMATION

Legal Name: _____ Preferred Name_____ Birth Date: _____
Last First Middle Initial

Sex: M / F *Preferred Language*: _____ *Ethnic Group*: ☐Hispanic ☐Latino ☐Neither *Race*: _____

Marital status: Married / Single / Divorced Spouse's Name: _____Phone _____

Patient Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code:_____

Email: _____ Preferred Contact Method: _____

Can Receive Texts Messages: ☐YES ☐NO Is it OK to Leave a Detailed Message: ☐YES ☐NO Would You Like to Receive Email Notifications: ☐YES ☐NO

Emergency Contact: _____ Phone Number: _____

Responsible Party ***(If Under 18 Years of Age):*** _____ *Date of Birth*: _____
Last First

Home Phone: _____ *Work Phone*: _____ *Mobile Phone*: _____

Street Address: _____ *City*: _____ *State*: _____ *Zip Code*:_____

INSURANCE INFORMATION

Primary Insurance Name : _____ Secondary Insurance Name:_____

Primary Insurance Policy Number:_____ Secondary Insurance Policy Number: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Policy Holder Date of Birth:_____ Policy Holder Date of Birth: _____

Primary Care Provider: _____

Referring Provider: _____

Reason for being seen today: _____

Is this the result of an accident or job injury? ☐YES ☐NO

MEDICATIONS

Preferred Pharmacy: _____ City: _____

Current Medications *DOSAGE & FREQUENCY*: _____

_____

HEALTH HISTORY:

Medical Conditions *(Please check those that apply)*:

Arthritis *Type*:	Anxiety	Kidney Disease	Neuropathy	Acid Reflux
Diabetes *Type*:	Depressed	Liver Disease	Slow Healing	Seizure Disorder
Cancer *Type*:	Chest Pain	Lung Disease	Hypertension	Heart Attack
Heart Disease:	Back Pain	HIV	Hearing Loss	Asthma
Bleeding Disorder:	Dizziness	Stroke	Ringing in Ear	Fibromyalgia
Skin Disorder:	Hyperthyroidism	High Cholesterol	Radiation Therapy	Osteomyelitis
Autoimmune Disorder:	*Other*	*Other*	*Other*	*Other*

Prior Surgeries or Hospitalizations (Within Past 2 Years): ☐NONE _____

_____

Podiatric Foot/Ankle Disease and Surgical History: ☐NONE _____

_____

Major Allergies: ☐NONE ☐Adhesive Tape ☐Latex ☐Aspirin ☐Penicillin ☐Sulfa Drugs
☐ Other: _____

Tobacco Use: ☐Never ☐Former ☐Current: _____ packs per day
Alcohol Use: ☐Never ☐Less than 1 Drink Per Day ☐1-2 Drinks Per Day ☐3+ Drinks Per Day
Recreational Drug Use: ☐Never ☐IV Drugs ☐Other: _____

Family History *(Please Specify Mother, Father, Brother, Sister, Daughter, or Son)*:
Diabetes Type: _____ Arthritis Type: _____
Heart Disease: _____ Cancer Type: _____
Stroke: _____ Other: _____

I hereby authorize this physician/clinic to release any information, for insurance purposes, required in the course of my examination or treatment.
SIGNED *(Patient or Responsible Party, if minor)*: _____ Date: _____

I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.
SIGNED *(Patient or Responsible Party, if minor)*: _____ Date: _____