Mountain View Foot & Ankle Institute

DAVID B. GLOVER, DPM, FACFAS

PATIENT INFORMATION

Legal Name: _____ Preferred Name_____
Last First Middle Initial

Birth Date: _____ Sex: M / F

Preferred Language: _____ *Ethnic Group*: ☐Hispanic ☐Latino ☐White ☐Other *Race*: _____

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

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

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 Policy Number:_____ Secondary 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

Who referred you to us: _____

The responsible party agrees to the following for the above listed individual (must be 18 years or older to provide signature)

- Assign all medical and/or Surgical benefits, to include major medical benefits to which I am entitles, Medicare, private insurance, and other health plan to physician rendering service.
- Grant permission to the physician to perform any medical treatment(s) necessary.
- Responsible for the charges not covered by my insurance and will pay it in a timely manner.
- Authorize my insurance benefits to be paid directly to Mountain View Foot and Ankle for the medical/surgical services received.
- I hereby authorize this physician/clinic to release any information for insurance claims or referral(s), required in the course of my examination or treatment.
- Responsible for keeping my insurance information up to date with the medical office.
- Responsible for payment at the time of service for copay, braces, walking boots, supplies not covered by insurance.
- I have read the HIPPA policy (on clipboard).

SIGNED *(Patient **or** Responsible Party, if minor)*: _____ Date: _____

TERMS AND CONDITIONS

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone number, or emergency numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree to terms listed above.

SIGNED *(Patient **or** Responsible Party, if minor)*: _____ Date: _____

MEDICATIONS

Preferred Pharmacy: _____ City: _____

Current Medications *DOSAGE & FREQUENCY*: _____

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

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

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MEDICAL INFORMATION RELEASE FORM

NAME: _____ DATE OF BIRTH: _____

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, examination, rendered to me, appointment information, and claims information. This information may be released to:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

☐ Information is not to be released to anyone.

I understand that

1. My records are protected and cannot be disclosed without written permission.
2. Once this facility discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.
3. I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 (164.524).
4. This authorization will remain in effect for one year or I provide a written notice of revocation to this facility.

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: _____