Dr. Jared L. Overman, 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#**________________________ **PHONE** ( ) ____________________
(required for unique identification) **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:

____

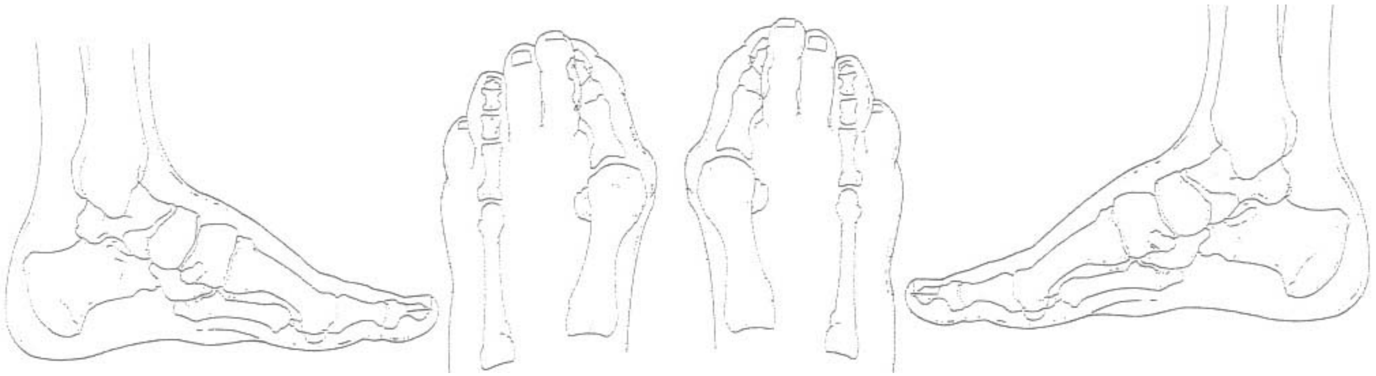
____

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:

☐ **Penicillin:** ______________________________

☐ **Codeine:** ______________________________

☐ **Latex:** ______________________________

☐ **Local Anesthetics:** ______________________________

☐ **Sulfa Drugs** ______________________________

☐ **Iodine / Shellfish** ______________________________

☐ **Aspirin:** ______________________________

☐ **General Anesthetics:** ______________________________

☐ **Metals / Earrings / Jewelry:** ______________________________

☐ **Other Medications:** ______________________________

☐ **Food Allergies :** ______________________________

☐ **Environmental Allergies :** ______________________________

☐ **Other:** ______________________________

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.

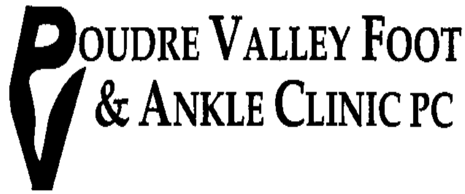
However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy and Security Officer at (970) 484-4620.

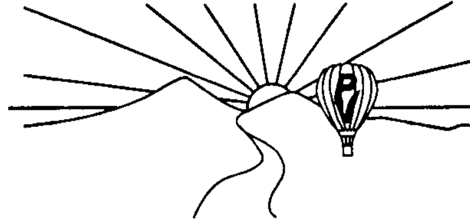
This notice goes into effect as of April 14, 2003.

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***:

________________________________ ____________________

Signature Date