Rocky Mountain Foot & Ankle

801-261-1391
5801 Fashion Blvd. #120, Murray, UT. 84107

Dr. Clark C. Larsen, DPM Dr. Thomas V. Eddy, DPM Dr. Daniel D. Hansen, DPM

DATE: ____________________

PATIENT NAME: ______________ ______________ ___ DATE OF BIRTH: ________________ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: ______________________________ CITY/STATE: __________________ ZIP: __________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-______ YES NO

WORK PHONE #: (____) ____-______ YES NO

CELL PHONE #: (____) ____-______ YES NO

E-MAIL: ______________________________ YES NO

PRIMARY LANGUAGE: _____________________

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: ______________________ RELATIONSHIP: __________ PHONE #: (____) ____-______

EMERGENCY CONTACT: ______________________ RELATIONSHIP: __________ PHONE #: (____) ____-_____

PRIMARY CARE DOCTOR: __________________________________ PHONE: ____________________

PHARMACY: _______________________ LOCATION: ____________________ PHONE #: (____) ____-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) ____

WHO IS RESPONSIBLE FOR PAYMENT? ________________________ RELATIONSHIP TO PATIENT? ____________

ADDRESS: ___________________ CITY/STATE: _____________ ZIP: _______ PHONE #: (____) ____-_____

WHO REFERRED YOU TO US? ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____

ADDRESS: ___________________ CITY/STATE: _____________ ZIP: _______ PHONE #: (____) ____-_____

INSURED NAME: _____________________ DATE OF BIRTH ___________ EMPLOYER ______________________

CONTRACT # ______________ GROUP # ________________

SECONDARY INSURANCE COMPANY NAME: ____

ADDRESS: ___________________ CITY/STATE: _____________ ZIP: _______ PHONE #: (____) ____-_____

INSURED NAME: _____________________ DATE OF BIRTH ___________ EMPLOYER ______________________

CONTRACT # ______________ GROUP # ________________

Patient Name: ______________________________

Date of Birth: ____________________

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

Name	Dose	How often do you take?

Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Please list all prior hospitalizations (other than for surgery):

Reason For Hospitalization	Date	Reason For Hospitalization	Date

Social History

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ No longer use ☐ History of alcohol abuse
☐ Current USE - Type ______________ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit – how long ago? _______ ☐ Smoke ___ packs/day for ___ years

Use of Recreational Drugs: ☐ Never ☐ Quit – How long ago? _______ Type __________________
☐ Current USE - Type ___________ ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily

Employer: ______________________________ Occupation: ______________________________

How much are you on your feet at work? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend upon you for their care? ☐ Children–age(s) _____ ☐ Pet(s)–what kind? _______
☐ Elderly or disabled family member ☐ Other ______________________________

Exercise: ☐ Never ☐ Rare ☐ Occasional ☐ weekly ☐ Several times a week ☐ Daily

Types of exercise: ____

Family History

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure
☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis
☐ Other ____

PATIENT NAME: ___________________________________

DATE OF BIRTH:______________________

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS ____

☐ ANESTHESIA ______________________________ ☐ FOODS ________________________________

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER ______________________________________

☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

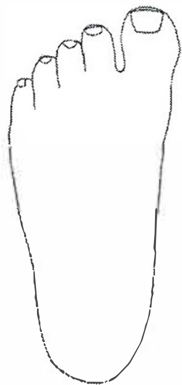
	Yes	No		Yes	No		Yes	No
ACID REFLUX		N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

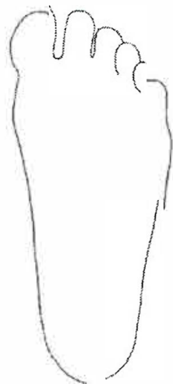
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

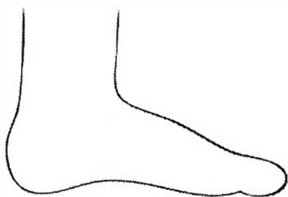
LEFT FOOT



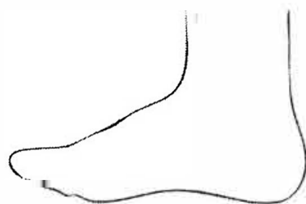
TOP OF FOOT



BOTTOM OF FOOT



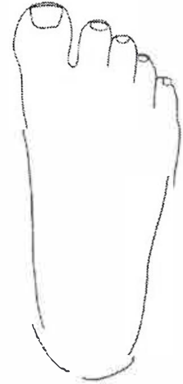
INSIDE OF FOOT



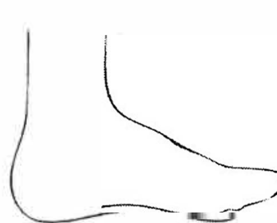
OUTSIDE OF FOOT

RIGHT FOOT

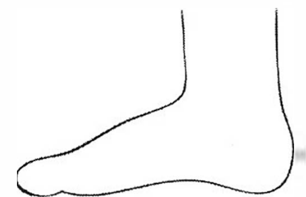
BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: ______________________________

DATE OF BIRTH: __________

HOW LONG AGO DID THIS PROBLEM FIRST START? ________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER ______________________________

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CHECK *(NO PAIN)* 0
1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER ______________________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ______________________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ______________________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ______________________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ______________________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

____
SIGNATURE OF DOCTOR

____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____
DATE

____
SIGNATURE

____
DATE

Clark C. Larsen, D.P.M.

Thomas V. Eddy, D.P.M. Daniel D. Hansen, D.P.M

We will submit to your insurance for the services provided. However, it is your responsibility to make sure that we have the correct information and to follow up with your insurance. If after 30 days we have not received payment from your insurance, the amount due must be paid by you. At 60 days, the account will be considered past due and interest will be charged.

Acknowledgement of receipt of privacy practices

I acknowledge that I have received a copy of Dr. Larsen's and Dr. Eddy's notice of privacy practices. This notice describes how Dr. Larsen and Dr. Eddy may use and disclose my information, certain restrictions on use, disclosure of health information and rights I may have regarding my protected health information.

X______________________________ Signature ________________ Date

Medicare Only

When you receive services and items that are not benefits of Medicare you are responsible to pay for them personally. Your insurance does not pay for all of your health costs. Your insurance only pays for covered benefits. When services or items are not benefits of your insurance they will not pay for them.

The purpose of the advanced notice is to help you make an informed decision regarding whether you want to receive those services, knowing you will have to pay for them yourself.

If you have any questions, as to what your insurance will cover, you can contact your insurance company. We will provide you with all information necessary, at your request.

X______________________________ Signature ________________ Date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: ____

Printed Name of Patient/Responsible Party ______________________________ Date: __________

_______ Patient initials to indicate copy received.

Revised June 2022