Alpine Foot & Ankle Clinic

FOOT & ANKLE CARE FOR THE WHOLE FAMILY

REGISTRATION FORM

(Please give insurance card(s) and photo ID to our Front Office Team)

Name (Last) _____ **(First)** _____ **(MI)** _____ **(Nickname)** _____

****Social Security #:** _____ **DOB:** _____ **Sex:** M or F

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Race:
___ African American
___ American Indian/Alaska Native
___ Asian
___ More than one race
___ Native Hawaiian/Pacific Islander
___ Unknown
___ White/Caucasian
___ Other:_____

Language
English
Spanish
Other: _____

Ethnicity
Hispanic/Latino
Non-Hispanic/Non-Latino

Marital Status: S M W D

Student: Yes No

Primary Care Physician (PCP): _____

Date Last Seen: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Preferred method of communication for patient reminders (choose ONE ONLY): Text / Phone / E-Mail

PATIENT PORTAL now available: Secure, confidential and EASY to use website to access your:
*Medical Records *Pay Your Bills *Request Rx Refills *Request Appointments *Receive Appointment Reminders

Please provide your E-MAIL if you are interested: _____

Would you like to receive our Educational Newsletter via email? Yes No

Payment Information/ Responsible Party: (If other than patient) ___N/A ___Self Pay

Adult accompanying minor (17 years of age or under) is responsible party

Responsible Party: _____ Birth date: _____SS# _____

Address: _____ City, State, Zip: _____

Employer: _____ Phone: _____

If self-pay or no SS# given when it's required by your insurance company– Payment in Full is expected at time of service*

Primary Insurance

Insurance Name: _____
Subscriber Name: _____
Date of Birth: _____
Subscriber ID#: _____
Group #: _____
Employer: _____

Secondary Insurance

Insurance Name: _____
Subscriber Name: _____
Date of Birth: _____
Subscriber ID#: _____
Group #:_____
Employer: _____

Dr. Gregg Neibauer, DPM
1845 Bancroft Street · Missoula, Montana 59801 · Phone (406) 721-4007 · www.alpinefoot.com

Patient Name_____ DOB_____

******Please tell us how you heard about us so we can better reach our community!******

____Drive by/Walk in ____Other: _____
____Established Patient ____Provider/Doctor Referral (Name): _____
____Friend/Family ____Website/Internet

MEDICAL HISTORY

Initial Podiatric History (Please answer all questions to best of your ability)
What is the reason for your visit? Is it the Right, Left, or Both Feet?

_____

_____

Describe any pain or disability and for how long: _____

_____

What causes the problem or make it worse? _____

Please explain any other pertinent background information: _____

_____

_____

What is your current occupation? _____

Please explain if it was caused by an injury: _____

Please explain if anything else affects the problem: _____

Please explain if there are any associated signs or symptoms: _____

_____

Please list any self-treatments you have tried: _____

Usual shoe size and width: _____ Usual shoe style: _____

MEDICATIONS: list all meds taken on a daily basis – include pills, injectables, and vitamins (use back if needed)

Medication Name	

Preferred Pharmacy:_____

Medication Allergy Section □ N/A

□ Penicillin □ Morphine □ Adhesive tape □ Aspirin □ Sulfa drugs □ Antibiotics
□ Suture □ Codeine □ Local anesthetic □ Iodine □ Latex □ Other_____

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Patient Name_____ **DOB**_____

Review of systems/current problems (Circle all that apply or circle N/A for non-applicable)

Constitutional **N/A**	Change in appetite Chills/rigors	Decreased activity Fatigue Fever	Irritability Lethargy Night sweats	Weakness Weight gain Weight loss
HEENT (Head, Ears, Eyes, Nose, and Throat) **N/A**	Blurred vision Double vision Difficulty swallowing	Ear drainage Facial pain Headache	Hearing loss Hoarseness Nasal congestion	Ringing in ears Vertigo Vision loss
Respiratory **N/A**	Asthma Cough	Difficulty breathing (dyspnea) Recent infections	Known TB exposure Wheezing	
Cardiovascular/ Vascular **N/A**	Chest pain (left) Heart murmur Leg swelling Syncope Irregular heartbeat / Palpitations	Atrial fibrillation Clotting disorder Color change toes/feet Congestive heart failure	Cool feet History of DVT Mitral valve prolapse Poor circulation	Raynaud's Rheumatic fever Thrombophlebitis Varicose Veins
Gastrointestinal **N/A**	Abdominal pain Constipation Black tarry stools	Diarrhea Heartburn/ Reflux disease Jaundice	Loss of appetite Nausea Vomiting	GI bleeds Stomach ulcers
Genitourinary **N/A**	Dysuria Frequent urination	Hematuria Urge incontinence	Urinary incontinence	Kidney problems
Metabolic/ Endocrine **N/A**	Cold intolerant Hair loss Heat intolerant	Diabetes type 1 Diabetes type 2	Excessive sweating Gout	Hypoglycemia Thyroid disease
Neurological **N/A**	Difficulty walking Dizziness Poor coordination Memory loss	Muscle weakness Paresthesia Seizures Tremors	Alzheimer's/Dementia MS Neuropathy Numbness in extremities	Restless leg syndrome Sciatica
Psychiatric **N/A**	Anxiety	Depression	Insomnia	
Integumentary / Dermatological **N/A**	Contact allergy Itchy skin Rash/dermatitis	Skin infections Skin lesions	Eczema Foot ulcers Ingrown toenails	Nail changes Psoriasis
Musculoskeletal **N/A**	Foot/ankle arthritis Foot/ankle fracture	Lumbar back pain Rheumatoid arthritis	Osteoarthritis	Unstable ankle
Hematological **N/A**	Bleeding Bruising	Anaphylaxis Autoimmune disorder	Clotting disorder	Swollen lymph nodes
Immunological **N/A**	Bee sting allergies	Contact dermatitis Environmental allergies	Food allergies	Seasonal allergies

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Patient Name_____ **DOB**_____

Past Medical and Surgical History N/A

Do you have any artificial joints or heart valves? ☐ Yes ☐ No

List foot and ankle surgeries and the year: _____

_____

Family History

Is there a family history of any of these disorders?

Allergies	Congestive heart failure	Liver disease	Peripheral vascular disease
Arthritis	Diabetes	Mental illness	Renal disease
Cancer	Gout	Migraines	Other: _____
Congenital heart disease	Hypertension	Osteoporosis	

Social History

Are you pregnant? No Yes N/A

Do you smoke? No (see below) Yes (Please list quantity per day): _____

If no, have you ever smoked? No Yes (Date quit): _____

Occupation

Employer:_____ **Job title:** _____

I certify the information given is accurate to the best of my knowledge.

_____ _____

Patient (or authorized representative) Signature **Date**

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