Alpine Foot & Ankle Clinic
FOOT & ANKLE CARE FOR THE WHOLE FAMILY

Updated 5/2020

REGISTRATION FORM

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

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

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

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

Home Phone: _____ **Cell Phone:** _____ **Preferred:** ☐ Home ☐ Cell

PATIENT PORTAL - 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

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Language:
- ☐ English
- ☐ Spanish
- ☐ Other

Race:
- ☐ African American
- ☐ American Indian/ Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Unknown
- ☐ White/Caucasian
- ☐ Other

Marital Status: (Circle one)
S M W D

Student Status:
Full Time Part Time N/A

Employment Status:
Full Time Part Time N/A

How did you hear about us?
- ☐ Drive by
- ☐ Established patient
- ☐ Friends/Family
- ☐ Insurance
- ☐ Internet/Website
- ☐ Other: _____
- ☐ Referral from another patient
- ☐ Provider: _____

Primary Care Physician: _____ **Date Last Seen:** _____

Billing Information:

Payment Information / Responsible Party: (If other than patient) ☐ N/A ☐ Self-Pay

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

Responsible Party: _____ **DOB:** _____ **Social Security #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____ **Phone:** _____

***If self-pay or no SSN 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 #: _____

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

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

Patient Name: _____ **DOB:** _____

PROBLEM 1:

Briefly describe the reason for your visit:

In which foot/ankle is the problem/pain: ☐ Left ☐ Right ☐ Both ☐ Foot ☐ Ankle

When did the problem/pain start: (# of) ☐ Days ☐ Weeks ☐ Months ☐ Years

Problem/pain occurs: ☐ While walking ☐ While not walking ☐ While standing ☐ First thing in the AM

Pain/discomfort can be described as: ☐ Shooting ☐ Throbbing ☐ Sharp ☐ Burning
☐ Dull/Aching ☐ Tender ☐ Tingling ☐ Numb ☐ None of these

Previous/current treatments: ☐ Anti-inflammatories ☐ Antibiotics ☐ Physical Therapy ☐ Bracing
☐ Over-the-counter orthotics ☐ Custom orthotics ☐ Surgery ☐ Doctor visit ☐ Other:

What is/are your goal(s) for treatment:

PROBLEM 2: (If applicable)

Briefly describe the reason for your visit:

In which foot/ankle is the problem/pain: ☐ Left ☐ Right ☐ Both ☐ Foot ☐ Ankle

When did the problem/pain start: (# of) ☐ Days ☐ Weeks ☐ Months ☐ Years

Problem/pain occurs: ☐ While walking ☐ While not walking ☐ While standing ☐ First thing in the AM

Pain/discomfort can be described as: ☐ Shooting ☐ Throbbing ☐ Sharp ☐ Burning
☐ Dull/Aching ☐ Tender ☐ Tingling ☐ Numb ☐ None of these

Previous/current treatments: ☐ Anti-inflammatories ☐ Antibiotics ☐ Physical Therapy ☐ Bracing
☐ Over-the-counter orthotics ☐ Custom orthotics ☐ Surgery ☐ Doctor visit ☐ Other:

What is/are your goal(s) for treatment:

What is your current shoe size: _____ **Usual shoe style:** _____

Have you fallen twice or more in the last year? ☐ Yes ☐ No
Please describe: _____
_____

Are you diabetic? ☐ Yes ☐ No **Circle One:** Type 1 Type 2
What was your last A1c: _____ **Fasting blood sugar today:** _____
Which physician manages your diabetes: _____

Height: _____ **Weight:** _____

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Patient Name: _____ **DOB:** _____

Preferred Pharmacy: _____

Medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Medication Allergies: ☐ N/A

☐ Adhesive tape ☐ Aspirin ☐ Iodine ☐ Local anesthetic ☐ Penicillin ☐ Suture
☐ Antibiotics ☐ Codeine ☐ Latex ☐ Morphine ☐ Sulfa Drugs ☐ Other: _____

Medical History:

Please indicate if you have/had any of the following conditions:

☐ Alzheimer's	☐ COPD	☐ Gout	☐ Lung Disease	☐ Parkinson's
☐ Arthritis	☐ Depression/Anxiety	☐ Headaches	☐ Migraines	☐ Seizures
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ MS	☐ Sleep Apnea
☐ Back Pain	☐ DVT (Blood clot)	☐ Hypertension	☐ Neck Pain	☐ Stroke
☐ Cancer	☐ Fibromyalgia	☐ Kidney Disease	☐ Neuropathy	☐ Thyroid Disease
☐ Cardiovascular History	☐ GERD	☐ Liver Disease	☐ Obesity	☐ Urinary Infections

Review of Systems:

Please indicate if you are currently having any of the following symptoms:

General:	☐ N/A ☐ Nausea ☐ Fever ☐ Chills ☐ Vomiting ☐ Fatigue ☐ Weakness
Cardiovascular:	☐ N/A ☐ Irregular heart beat ☐ Rapid heartbeat ☐ Leg/ankle swelling ☐ Pain in legs while walking ☐ Cramping in legs while walking
Gastrointestinal:	☐N/A ☐ GERD/heartburn ☐ Stomach ulcers ☐ GI bleeding
Endocrine:	☐ N/A ☐ Hyperglycemia/Diabetes
Musculoskeletal:	☐ N/A ☐ Unstable walking ☐ Poor balance ☐ Falls ☐ Low back pain ☐ Joint pain/swelling feet ☐ Joint pain/swelling ankles
Neurological:	☐ N/A ☐ Numbness feet/legs ☐ Burning feet/legs ☐ Tingling feet/legs ☐ Sciatica/radiating nerve pain from spine

Surgical History:

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

If yes, please describe: _____

List any other lower extremity or cardiovascular surgeries: _____

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Family History:

Please indicate if your mother or father had any of the following disorders:

Arthritis	☐ N/A	☐ Mother	☐ Father
Cancer	☐ N/A	☐ Mother	☐ Father
Diabetes	☐ N/A	☐ Mother	☐ Father
Hypertension	☐ N/A	☐ Mother	☐ Father

Social History:

Are you pregnant? ☐ N/A ☐ No ☐ Yes

Occupation: _____ **Employer:** _____

Do You Smoke? ☐ No ☐ Yes (How much do you smoke per day?): _____

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

Have you had a flu vaccine this year? ☐ No ☐ Yes

Have you had a pneumonia vaccine this year? ☐ No ☐ Yes

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

_____ _____ _____

Patient Signature (Authorized Representative) **DOB** **Date of Visit**

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