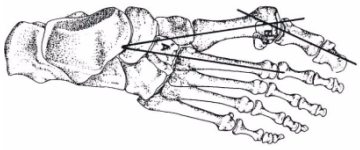

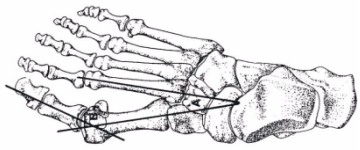

Dr. Spence D. Harper
Welcome to our office

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. If you have questions regarding our health information privacy policies, please inquire the front office for a copy of our policies.

Patient Information			
Patient Name: *(Last, First, M.I.)* ☐ M ☐ F		**DO B:**	**AGE:**
Address: *(street, city, state, zip)*		**Social Security Number:**	
Preferred Phone Number:		**Alternate Phone Number:**	
Email Address: *(used for appointment reminders, newsletters, billing inquiries and the Patient Portal)*			
Occupation:		**Employer:**	
Marital status: ☐ Single ☐Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Spouses Name (if applicable):			
Who may we thank for the referral to our office?		**Date of last physical exam:**	
Is your billing address different than the one listed above? ☐ Yes ☐ No		If yes, please list your billing address below	
Billing Address: *(street or PO box, city, state, zip)*			

CONTACT IN CASE OF EMERGENCY		
Name:	Relationship:	Phone Number:

RESPONSIBLE PARTY *(if patient is a minor or under another's care)*		
Name:	Relationship:	DOB:
Phone Number:	Social Security Number:	

INSURANCE INFORMATION		
Is the patient the primary subscriber to this insurance? ☐ Yes ☐ No	If no, what is the subscribers first and last name, date of birth, and policy number (if different than the patients' policy number)?	
Subscriber Name:	**DOB:** ____/____/_____	**Policy Number:**
How is the patient related to the subscriber?		

Primary Insurance Company: *(insurance to be billed first)*	
Policy Number or Member ID:	**Group Number:**
Secondary Insurance Company: *(if applicable)*	
Policy Number or Member ID:	**Group Number:**

Preferred Pharmacy	
Pharmacy Name:	**Phone Number:**
Pharmacy Address: *(street, city, state, zip)*	

Medications and Past Medical History		
If more than six medications- a list is required		
Are you currently prescribed any medications? ☐ Yes ☐ No **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**		
Name of the Drug	Strength	Frequency Taken
Allergies to medications or medical supplies such as latex, adhesive tape, or local anesthetic:		
Name of the Drug or product	Reaction You Had	

Are you Diabetic or Pre-Diabetic? ☐ Yes ☐ No	If yes, please list your most recent Hemoglobin A1c: *(usually a number between 6 & 12)*	
Do you have a primary care doctor? ☐ Yes ☐ No	Name of Primary care doctor:	
Have you ever been diagnosed with any of the following? (circle all that apply)		
-Cardiovascular problem - Angina - Heart Attack - Heart Disease - Congestive Heart Failure - Blood Clots or DVT - High Blood Pressure - Artificial Heart Valves - Heart Murmur - Skin Disorders - Cellulitis / Skin infection - Large Scars - Slow Healing Sores - Endocrine Disorders - Diabetes - Hypothyroidism -Stomach / Bowel Conditions - GI bleed / Ulceration - Hepatitis	-Kidney Disease - Liver Disease - Nose / Throat Problems - Hearing Loss - Macular Degeneration - Retinopathy - Blindness - Bleeding Disorder - High Cholesterol - Immunologic Disorder - AIDS / HIV - Anaphylactic Reaction - Lupus - Tuberculosis - Swollen Lymph Nodes - Venereal Disease - Rheumatic Fever - Musculoskeletal Disorder - Artificial Joint	- Degenerative Arthritis - Rheumatoid Arthritis - Osteoarthritis - Gout - Back Pain - Fibromyalgia - Osteomyelitis - Neurological Disorder - Neuropathy - Sciatica - Seizure Disorder - Stroke - Depression -Chemical Dependency - Respiratory Disorder - Asthma - Pulmonary Embolism - Shortness of Breath - Cancer

Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

Have you ever had complications or infections from past medical interventions? ☐ **Yes** ☐ **No**	**If yes, please explain**
Date: **Nature of Complication:**	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat on an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Alcohol	Do you drink alcohol? ☐ Yes ☐ No					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years:	☐ Or year quit:				
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

PLEASE LIST ANY SIGNIFICANT HEALTH PROBLEMS ASSOCIATED WITH THE APPROPRIATE RELATION BELOW

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

PODIATRIC HISTORY

What is the chief reason for being seen today?	
Is this condition the result of a work injury? ☐ Yes ☐ No	If yes, please briefly explain below

Which Foot / ankle is affected?	☐ Right	☐ Left	☐ Both	
What is the quality of the ailment pain (mark all that apply)?	☐ Aching	☐ Stabbing	☐ Pain after rest	
	☐ Sharp	☐ Pins & needles	☐ Dull	
	☐ Nauseating	☐ Crushing	☐ Tender	
	☐ Burning	☐ Shooting	☐ Inconsistent	
	☐ Pulling	☐ Swelling	☐ Throbbing	
	☐ Tingling	☐ Disabling		
	☐ Constant	☐ Radiating		

How long has the condition been present?		
What is the usual onset of the pain (mark all that apply)?	☐ Gradual ☐ Sudden ☐ Unknown ☐ Primarily at night	☐ With exercise
What is the cause of the ailment (mark all that apply)?	☐ No trauma ☐ Improper foot gear ☐ Blunt injury ☐ Sports injury ☐ Cut from sharp object	☐ Auto accident ☐ Work injury ☐ Trip or fall ☐ Other_____
What treatments, if any, have you tried pain (mark all that apply)?	☐ None ☐ Orthotics / arch support ☐ Change / modify shoe gear	☐ Physical therapy ☐ Antibiotics ☐ NSAIDs ☐ Other _____
Have you ever seen a podiatrist before?	☐ Yes ☐ No	If yes, who was the doctor and what was the circumstance?

Consent of Release

In my absence, I authorize Dr. Spence D. Harper's office to release all or portions of my medical records to those as indicated below. This authorization is in effect for a full year or until I revoke it in writing.

□ Name:_____ □ Name:_____

□ Name:_____ □ Name:_____

X_____ X_____

Signature of patient or parent / authorized representative Date

HIPAA Notice of Privacy Practices

I acknowledge that I was provided access to a copy of the **Privacy Practices Policies** and that I have read (or had the opportunity to read if I so chose) and understand the notice.

X_____

Signature of patient or parent / authorized representative

X_____ X_____

Print Name Date

Assignment, Release & Consent

- I request that payment of authorized insurance benefits be made on my behalf to Dr. Spence D. Harper or Wasatch Foot and Ankle Center for any service furnished. I authorize the release of medical information about me needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim.
- I understand that I am financially responsible for all charges whether or not paid by insurance. A financial fee of 1.5% per month will be added to all accounts past due. Delinquent accounts over 90 days past due will automatically be sent to a collection agency. Should collections become necessary, the responsible party agrees to pay an additional 35% collection fee and all legal fees, with or without suit including attorney fees and court costs. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.
- I understand that I may be billed for appointments that I miss without cancelling or rescheduling at least 24 hours in advance.
- I certify that the above information is true and correct to the best of my knowledge. I hereby give my permission to Dr. Spence D. Harper and Wasatch Foot and Ankle Center to administer and perform such procedures and tests as may be deemed necessary in the diagnosis and treatment of my feet/ankles. I authorize the use of photography for documentation and/or educational purposes.

X_____ X_____

Signature of patient or parent / authorized representative Date