Stephen E Latter, DPM
58 Village Loop Rd
Kalispell, MT 59901
406-755-5250

KALISPELL FOOT & ANKLE CLINIC

Please take a moment to review, making sure all fields are accurate and correct.

Patient Legal Name_____

Date of Birth_____Social Security Number_____

Mailing Address_____

City/State/Zip_____

Primary Phone _____Ok to leave message? Yes No

Secondary Phone_____ _____Ok to leave message? Yes No

Do we have permission to discuss your medical condition with any member of your household? Yes No

If yes, whom_____Relationship to you_____Phone #_____

Primary Care Doctor/Date of last visit_____ Pharmacy_____

Insurance Information (Please give cards to the receptionist)

Primary Insurance_____ Policy #_____Group #_____

Subscriber Name & Date of Birth_____ Relationship to Patient_____

Secondary Insurance_____Policy #_____ Group#_____

Subscriber Name & Date of Birth_____ Relationship To Patient_____

Minor Patient's Responsible Party_____

How did you hear about our office? Doctor Friend/Relative Internet Phone Book Other_____

****

I understand this office is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This is to keep my protected health information private. I understand that the office HIPAA policy is available to me upon request. I permit release of information concerning dates of treatment, condition, diagnosis or procedures to my personal physician, referring physician and/or the referring facility or to another facility/provider for follow-up care. My signature below authorizes the release of any medical information necessary to process claims and request that payment of all assigned benefits be made to the provider of services. I understand that I am financially responsible for non-covered benefits, deductibles and co-payments at the time of service. Should the account be referred to a collection agent, the undersigned shall pay all collection expenses.

_____

Date Patient Name Signature of Patient/Responsible Party

*****Please Complete Page 2****

Medical History

Patient's height_____ Patient's Weight_____ Patient's Shoe Size_____

Briefly describe your current foot problem_____

_____

Please circle any of the following conditions you now have or have had previously:

Heart Disease	Circulation Issues	Diabetes	Breathing/Lung Problems
Cancer	Arthritis	Anemia	High Blood Pressure
Blood Clots	Gout	Stroke	Thyroid

Other_____

Does your family (mother, father or siblings) have any history of the following conditions? (please circle)

Heart Disease	Diabetes	Stroke	Cancer
Hammertoes	Bunions	Flat Feet	

Please list any medications you are presently taking: _____

_____

_____

Are you allergic to any of the following? (Please Circle)

Penicillin	Amoxicillin	Sulfa Drugs	Codeine	Latex
Iodine	Aspirin	Anti-inflammatories	Local Anesthesia	Tape/Bandaids
Shellfish	Other_____			

My signature acknowledges the above is correct to the best of my knowledge.

Patient's Signature _____ Date_____

Patient's Name_____ Date of Birth_____