CHRISTENSEN FOOT AND ANKLE CLINC
1777 EAST CLARK STREET STE #220
POCATELLO, IDAHO 83201
PHONE: 235-1777 FAX: 232-7518

WELCOME TO OUR OFFICE:

DATE: _____

LAST NAME:_____FIRST NAME:_____MIDDLE INITIAL_____

ADDRESS:_____CITIY/STATE_____ZIP:_____

EMAIL_____PHONE:_____CELL:_____

DOB: _____AGE:_____GENDER: MALE FEMALE SOC. SEC. #_____

PRIMARY LANGUAGE: _____ RACE: WHITE BLACK AMERICAN INDIAN ASIAN

ETHNICITY: NON HISPANIC/LATINO HISPANIC/LATINO

HOW DID YOU LEARN ABOUT OUR OFFICE? INTERNET_____YELLOW PAGES_____PATIENT (NAME) _____

EMPLOYERS NAME:_____EMPLOYERS PHONE: _____

EMERGENCY CONTACT NAME: _____RELATIONSHIP_____

PHONE:_____ CELL:_____

PRIMARY INSURANCE: _____POLICY #_____GROUP #_____

POLICY HOLDER: _____RELATIONSHIP:_____DOB:_____

SECONDARY INSURANCE:_____POLICY#_____GROUP#_____

POLICY HOLDER:_____RELATIONSHIP: _____DOB:_____

I AUTHORIZE DR. BRENT CHRISTENSEN AND/OR ASSISTANTS TO RENDER PORPSED EXAMINATION AND TREATMENT. I AUTHORIZE RELEASE OF ANY MEDICAL RECORDS NECESSARY TO FACILITATE CONSULTATION ON MY CARE, OR TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE DIRECT PAYMENT OF ALL RELATED INSURANCE BENEFITS TO CHRISTENSEN FOOT AND ANKLE CLINIC. I ACCEPT FULL RESPONSIBILTY FOR PROFESSIONAL SERVICES AND MATERIALS PROVIDED RENDERING TREAMTENT, AS WELL AS ANY ACCOUNT SERVICE CHARGES WHICH MAY APPLY.
I WAS PROVIDED A COPY OF THE NOTICE OF PRIVCY PRACTICES AND I HAVE HAD THE OPPORTUNITY TO READ AND I UNDERSTAND THE NOTICE.

SIGNATURE OF PATIENT OR REPSONSIBLE PARTY:_____

ALLERGIES:

_____ADHESIVE TAPE	_____CODEINE	_____LOCAL ANESTHETICS	_____SEAFOOD
_____ANTI COAGULANT THERAPY	_____DEMORAL	_____NOVACAIN	_____SULFA
_____ASPIRIN	_____IODINE	_____PENICILLIN	_____OTHER

MEDICATIONS: LIST ALL PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS:

MEDICAL HISTORY: CIRCLE ALL THAT APPLY

AIDS/HIV	DIABETES I	HIGH BLOODPRESSURE	SWELLING IN FEET
ANEMIA	DIABETES II	HIGH CHOLESTEROL	THYROID ISSUES
ANGINA	DRUG USE	KIDNEY DISEASE	VARICOSE VEINS
ARTHRITIS	HEARING LOSS	LIVER DISEASE	OTHER_____
ARTIFICIAL JOINTS	EPILEPSY	LOW BLOOD PRESSURE	_____
ASTHMA	FAINTING	NERVOUS PROBLEMS	_____
BACK PROBLEM	FOOT AND LEG CRAMPS	RADIATION TREATMENTS	
BLEEDING DISORDER	GOUT	RESPIRATORY DISEASE	
CANCER	HEPATITIS	RHEUMATIC FEVER	
CIRCULATORY PROBLEMS	HEART DISEASE	STROKE	

HAVE YOU EVER SMOKED? YES / NO DO YOU SMOKE NOW? YES/NO HEIGHT: _____WEIGHT:_____SHOE SIZE:_____

PAST SURGICAL HISTORY:_____

PRIMARY CARE PHYSICIAN_____LAST VISIT DATE:_____

PREFERRED PHARMACY:_____

FAMILY MEDICAL HISTORY:

CONDITION	RELATIVE	CONDITION	RELATIVE
ARTHRITIS	_____	HEART CONDITION	_____
CANCER	_____	HIGH BLOOD PRESSURE	_____
DIABETES	_____	KIDNEY DISEASE	_____

CONSENT: I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY PERMISSION TO DR. CHRISTENSEN TO ADMINISTER AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY FEET/ANKLES.

SIGNATURE: _____DATE:_____

DOCTORS SIGNATURE: _____DATE:_____