Denver Foot and Ankle Surgery-formerly Foot Specialist Associates, PC

4055 S. Broadway | Englewood, CO 80113 | (303) 722-6864 | Fax: (303) 722-5113

Patient Registration

Patient Name: _____ Birth Date: _____ Age: _____

Address: _____ Unit #: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Soc Sec #: _____

Preferred Phone: _____ ☐C ☐H ☐W Alt Phone: _____ ☐C ☐H ☐W

Email (for appointment reminders): _____

Sex Assigned at Birth: ◯ Male ◯ Female ◯ Unknown

Gender Identity: ◯ Male ◯ Female ◯ Transgender M→F ◯ Transgender F→M
◯ Non-binary ◯ Genderqueer ◯ Other

Responsible Party

Name: _____ Birth Date: _____

Address: _____ Unit #: _____

City: _____ State: _____ Zip: _____

Soc Sec #: _____ Phone: _____ Relationship to Patient: _____

Providers & Referral

Referred by: _____ Family Physician: _____

Physician Office Phone: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Primary Insurance

Insurance Co.: _____ Phone: _____

Policy ID: _____ Group ID: _____ Insured Birth: _____

Insured Name: _____ Relationship: _____

Secondary Insurance

Insurance Co.: _____ Phone: _____

Policy ID: _____ Group ID: _____ Insured Birth: _____

Insured Name: _____ Relationship: _____

I am aware that my account and knowledge of insurance benefits is my responsibility. Foot Specialist Associates, PC cannot guarantee payment, benefits or coverage from my insurance company. I authorize my insurance benefits to be paid directly to Foot Specialists Associates, PC. I authorize the facility to release medical information for treatment, payment or daily operations. I voluntarily consent to examination and treatment for myself or the above dependent patient. I will inform Foot Specialist Associates, PC immediately of any insurance or personal information changes. I have read all the above information and asked any necessary questions.

Signature: _____ Date: _____

Medical History

Patient Name: _____ Birth Date: _____

Describe your foot or ankle problem: _____

_____

_____

Past Medical History ☐ None (skip to Allergies)

☐ Anemia	☐ Arthritis/Rheumatism	☐ Asthma	☐ Bleeding Disorder	☐ Blood Clots
☐ Bowel Disease	☐ Cancer	☐ Depression	☐ Diabetes Type I	☐ Diabetes Type II
☐ Diphtheria	☐ Epilepsy	☐ Frequent Infections	☐ Glaucoma	☐ Gout
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS
☐ Measles/Mumps	☐ Mental Illness	☐ Mitral Valve Prolapse	☐ Osteoporosis	☐ Pacemaker
☐ Peripheral Vascular	☐ Polio	☐ Rheumatic Fever	☐ Rubella	☐ Scarlet Fever
☐ Skin Disease	☐ Stomach Ulcers	☐ Stroke	☐ TB	☐ Thyroid Disease
☐ Varicose Veins	☐ Venereal Disease			

Other: _____

Allergies — check all that apply ☐ None (skip to Medications)

☐ Adhesive/tapes	☐ Antihistamines	☐ Aspirin	☐ Codeine	☐ Demerol
☐ Iodine	☐ Latex	☐ Mercurials	☐ Merthiolates	☐ Mycins/other
☐ Novocain	☐ Nylon/plastics	☐ Penicillin	☐ Sulfa	☐ Tetanus antitoxin

Other: _____

Current Medications ☐ None (skip to Surgical History)

Please list prescriptions, over-the-counter medications, and vitamins with dosages, strengths, and instructions:

_____

_____

_____

Last tetanus shot: _____ Blood transfusion: ☐ Yes ☐ No Pregnant: ☐ Yes ☐ No

Habits: Smoking — Daily Amt: _____ Former? ☐ Never? ☐

Alcohol: _____ Caffeine: _____

Surgical History ☐ None (skip to Family History)

_____

_____

_____

Family History ☐ None (skip to Agreement)

Condition	Mother	Father	Unknown	Condition	Mother	Father	Unknown
Bleeding Disorder	☐	☐	☐	High Blood Pressure	☐	☐	☐
Cancer	☐	☐	☐	Kidney Disease	☐	☐	☐
Diabetes	☐	☐	☐	Mental Illness	☐	☐	☐
Epilepsy/convulsions	☐	☐	☐	Osteoporosis	☐	☐	☐
Glaucoma	☐	☐	☐	Stroke	☐	☐	☐
Heart Disease	☐	☐	☐	Thyroid Disease	☐	☐	☐

Other: _____

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Agreement / Conditions of Treatment

I understand my physician(s) will use their best skill and judgment to accomplish the desired result.
I understand my physician(s) cannot or does not warrant or guarantee such results.
The forecast of recovery time is based on similar cases; my result may differ.
On my part, I promise full cooperation in my treatment, whether by surgical or nonsurgical means.
I understand if I don't follow instructions, it could jeopardize the outcome and cause a negative result.

Signature: _____ Date: _____

Print Name: _____

Acknowledgment of Receipt of Notice of Privacy Practices

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

Patient Name (please print): _____

Date: _____

Parent or Authorized Representative Signature: _____

No Show / Late Cancellation Policy

No Show and Same-Day Cancel/Reschedule

Foot Specialists Associates is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. While we understand that emergencies do arise, please provide at least 24 hours notice in the event that you are unable to make an appointment or need to reschedule. Call (303) 722-6864 to cancel at least 24 hours before your appointment. For a Monday appointment, please call our office by 12:00 p.m. on Friday.

A missed appointment without notice (no show) or same-day cancellation will result in a $30.00 late-cancellation fee. Emergency situations may be considered exceptions — please contact us prior to your scheduled appointment time. Patients who no-show three (3) or more times in a 12-month period may be dismissed from the practice.

Late Policy

If you arrive more than 10 minutes late, we will make every effort to accommodate you but may need to reschedule. If rescheduled, you may be subject to the late-cancellation fee. As a courtesy, reminder calls, texts, and emails will be sent in advance — please ensure we have your current contact information.

Please initial, sign, and date below to indicate that you have read and understand this policy.

_____ (initial) I understand the late cancellation fee is the patient's sole financial responsibility and is not billable to insurance.

Patient Signature: _____ Date: _____

Patient Name (please print): _____