Rimrock Podiatry
1690 Rimrock Road, Suite L
Billings, Montana 59102
(406) 256-0077

Patient Health Questionaire

When did you last see your regular doctor _____

Doctor's name and address: _____

_____

Referred by: _____.

Shoe Size: _____ Height: _____ Weight: _____

Are you currently taking any medications? YES NO

If so, please list: _____

_____

Do you have any known allergies? YES NO

If so, please list: _____

_____

Do you have any other physical condition we should be aware of such as: Diabetes, Heart Trouble, Epilepsy, etc? YES NO

Do you have any artificial joints or a condition requiring antibiotics prior to a surgical procedure? YES NO

If so, please list: _____

_____

Patient Signature_____ Date: _____

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☐ **DR. WILLIAM O'REILLY** **DR. S☐TT DEMARS** **DR. MERRI☐ KAUWE**

First Name_____MI _____ Last Name_____

Birthdate_____ Age _____ SSN#_____ Sex: M_____ F_____

Address_____Apt _____

City_____State_____Zip_____

Home Phone_____ Cell/Other Phone_____

Parent/Guardian/Spouse: (Responsible Party) **Name_____ Birthdate _____**

Address: _____

City_____ State_____ Zip_____

Emergency Contact: _____Relationship_____ Phone _____

Primary Care Physician _____

INSURANCE INFORMATION

Primary Insurance _____Policy # _____
Policy Owner
SS# if Policy #

Policy Owner _____ Birthdate
_____

Secondary Insurance _____ Policy # _____
Policy Owner SS# if Policy #

Policy Owner _____ Birthdate _____

____Medicaid -- please provide PASSPORT PROVIDER: _____ Auth _____

____Work Comp (complete attached info sheet) Date of Injury _____

____Auto Accident (complete attached info sheet) Date of Injury _____

I authorize the release of any medical or other information to process this claim. I understand that, although insurance may or may not cover part of my charges, I am responsible for payment, and I authorize payment of my insurance to be paid directly to the provider.

_____ _____
Responsible Party Signature **Date**