Rimrock Podiatry PLLP

Dr. DeMars ☐ Dr. Lubek ☐ Dr. Kauwe ☐

First Name: ____________________ MI:____ Last Name: ___________________________

Birthdate: ________________ Age:______ Gender: M______ F ______

Occupation: ___________________________ Ethnicity: __________________________

Address: ____ Apt: _____________

City: ________________________________ State: _________ Zip: ______________

Home Phone: ____________________ Cell/Other Phone #: _____________________

Parent/Guardian/Spouse:
(Responsible Party)

Name: ________________________________ DOB: ____________

Address: ____

City: _________________________ State: ______ Zip: _________

Emergency Contact: _________________ Relationship: ________________ Ph. ___________

Referring Physician: _________________________________ Date Last Seen: _____________

INSURANCE INFORMATION:

Primary Insurance: __________________________________ Policy #: _____________________

Policy Owner: _______________________________ DOB: _____________________

Secondary Insurance: _________________________________ Policy #: ___________________

_________ Medicaid - PROVIDE PASSPORT PROVIDER: _______________________________

_________ Work Comp (See additional form) Date of Injury: ______________________________

_________ Auto Accident (See additional form) Date of Injury: ____________________________

I indicate by my signature on this form that I consent to the medical treatment recommended and agreed upon by my physician. 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:

Rimrock Podiatry PLLP

PATIENT HEALTH QUESTIONNAIRE

Patient Name:____

When did you last see your primary care doctor?:____

Primary Doctor's name:____

Referred by?____

Shoe size_____________________Height___________________ Weight_______________________

Please list any allergies:____

____

Please list any current or past health conditions:____

____

Do you have any artificial joints or conditions requiring antibiotics prior to a medical procedure?_____

____

Tobacco Use:

Current Smoker/Chew/ Vaping_______

Former Smoker/Chew/Vaping________

Never Used______

Vaccination Screening:

Have you had the following vaccines? :

Pneumococcal (Pneumonia)_________

Influenza (Flu)_____________

Patient Signature_____________________________________Date____________________________

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:____

DOB____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Rimrock Podiatry PLLP Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Rimrock Podiatry, PLLP.

____

Signature of Patient Date

____

Signature of Parent, Guardian or Personal Representative* Date

____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

X Circle here if Patient/Client Refuses to Acknowledge Receipt:

____

Signature of Staff Member