

Dr Webb Foot & Ankle Clinic

Emily Webb, DPM

1927 Wilmington Dr., Suite 102
Fort Collins, CO 80528
(970) 460-6575 Fax (970) 416-9010

Personal Information

Name: _____ Birth date: _____ Today's date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Cellular phone: _____
Email address: _____

Preferred method of appointment reminders: Email Text Phone

Age: _____ Gender: M / F Occupation: _____
Employer: _____ Work phone: _____
Preferred pharmacy: _____ Location: _____
Primary family physician: _____
How did you hear of our clinic? _____
Marriage status (circle): Single Married Widowed Other
Emergency contact: Name _____
Relationship: _____ Phone number: _____

Today, my foot/ankle complaint is: _____

The condition(s) has existed for (how long)? _____
Is this related to a specific injury? _____ Date of injury? _____
Have you had this problem before? _____ How long ago? _____
Previous treatment(s)? _____

Allergic to latex? Yes No What reactions do you get if "yes"? _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Review of Systems: (check all that applies)

_____ In general good health _____ Recent significant weight gain _____ Recent significant weight loss

Eyes: _____ Does not apply _____ Cataracts _____ Glaucoma _____ Macular degeneration

Ears/Nose/Mouth/Throat: _____ Does not apply _____ Sinusitis _____

_____ Difficulty hearing _____ Using hearing aids _____ Others (please describe)

Cardiovascular: _____ Does not apply _____ History of heart attack _____ DVT _____ High blood pressure

_____ History of stroke _____ Heart murmurs _____ Others (please describe)

Gastrointestinal: _____ Does not apply _____ History of stomach ulcer _____ IBS _____ Heartburn/gastric reflux

_____ Hiatal hernia _____ Hepatitis (A/B/C) _____ Cirrhosis _____ Fatty Liver _____ Others (please describe)

Genitourinary: _____ Does not apply _____ Kidney stones _____ Benign prostate hypertrophy (in men)

_____ Overactive bladder _____ Frequent UTI _____ Others (please describe)

Musculoskeletal: _____ Does not apply _____ Rheumatoid arthritis _____ Psoriatic arthritis _____ Osteoporosis

_____ Osteopenia _____ Lower back pain/arthritis/herniated disc/pinch nerve

Osteoarthritis(where? _____) Sciatica _____ Others (describe) _____
Skin: Does not apply Eczema History of Athlete's foot _____ Others (describe) _____
Neurological: Does not apply Migraine headache _____ Numbness of hands _____ Seizures _____
 Numbness of feet _____ Multiple sclerosis _____ Charcot-Marie-Tooth disease _____ Parkinson's _____
Psychiatric: Does not apply Depression _____ Anxiety _____ Bipolar disorder _____ ADHD _____
 Others (describe) _____
Endocrine: Does not apply Gout _____ Diabetes _____ Thyroid problems _____ Others(describe) _____
Hematologic: Does not apply Bleeding disorder _____ Anemia _____ Others(describe) _____
Allergic/Immunologic: Does not apply Auto-immune disease _____ HIV positive _____
Clotting Disorders: _____ (please describe)

What operations or surgeries have you had? _____

Yes **No** Do you smoke tobacco? If **yes**, how much? _____ Smoking how long? _____

If **no**, did you smoke in the past? _____ When did you quit? _____

Yes **No** Do you use recreational drugs? If **yes**, how much? _____ Using how long? _____

If **no**, did you use in the past? _____ When did you quit? _____

Yes **No** Do you drink alcohol? How much do you drink? _____

Yes **No** Do you exercise on a regular basis? If yes, please describe. _____

Does anything significant run in your family? (i.e. heart disease, diabetes, clotting disorders, foot deformities)

Please list all conditions.

If there's anything else in your medical history that may be important for your physician to know in order to facilitate your treatment? Please describe: _____

OUR COMMITMENT TO RESPECT YOUR HIPAA PRIVACY

Our clinic is committed to respecting your privacy. We are dedicated to keep your health information private and only share it with those parties that need it for treatment of your health condition, for example, your primary care physician or a physical therapist whom we refer you to. At any time that you feel that you would like more information on our clinic's privacy practices or you have a concern, please let your provider know so that we may take actions to rectify the situation. We truly value our patients and are committed to helping them achieve the best outcome.

I, _____ hereby consent to the use, access, and disclosure of my protected health information to (a third party):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

No one.

I acknowledge that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature: _____ Date: _____

Dr Webb Foot & Ankle Clinic
Emily Webb, DPM
1927 Wilmington Drive, Suite 102
Fort Collins, CO 80528

Clinic Policies

Financial Policy

I understand Dr. Webb opted out of all insurance, including Medicare and Medicaid.

If I have any insurance, I understand no claims can be submitted by the clinic for my visit(s). I accept full responsibility for payment. All payments are due at the end of each visit. The fees are listed on the website:
<https://www.emilywebb.info/foot-doctor/making-appointment/>

We currently accept cash, checks, or credit cards for payment. There will be a 3% discount if paying with cash or checks.

Medical Records Authorization

I authorize Dr Webb Foot & Ankle Clinic to access and use the protected health information from UC Health and/or Banner Health systems for the purpose of my treatment. Protected health information includes my complete health record including but not limited to: chart notes, radiology images, MRI images, lab test results and medication list.

Medical Records Policy

A minimum of seven working days is needed to release medical records or x-rays from the request date. All requests must be in writing. (Please refer to our Medical Records Release Form for detailed information on costs and instructions.)

Prescription Refill Policy

I understand a minimum of three working days for any prescription refill request is required. I understand no Rx refill request on holidays or weekends can be made, as the on-call physician may not have my medical record.

Colorado Prescription Drug Monitoring Program (PDMP)

If I receive a prescription for a "controlled" drug (Schedule II through V), e.g. opioids, this information will be entered into the Colorado PDMP database. This information is shared and may be accessed by the health providers who will and have prescribed to me these medications.

Appointment Policy

I am NOT currently in an emergency or urgent medical situation.

If I have a contagious illness such as COVID, a cold or flu, even mild, I will call to reschedule my appointment. I understand the clinic wants to protect the health of their staff members and of other patients, who are often elderly and vulnerable with a weaker immune system. Once I am recovered from my symptoms, I will return for my appointment. *(Thank you very much for your understanding and cooperation.)*

Appointments are scheduled at times mutually convenient to the patient and doctor. It is understood that urgent or unexpected situations may arise which may prevent me from keeping my appointment. If I am unable to keep a scheduled appointment, I will call (970) 416-9009 to cancel at least 24 hours ahead of my appointment time so that my

allotted time may be offered to another patient. If I show up more than 10 minutes late to my appointment, I may need to be rescheduled. The clinic staff reserves the right to reschedule appointments.

A \$75.00 fee and documentation will be implemented if I do not show up for my appointment or cancel within 24 hours of my appointment. The \$75.00 fee must be paid before another appointment can be scheduled for me. Continuing to miss appointments or repeated last-minute cancellations may result in dismissal from the clinic.

The treating physician can get ill or encounter unexpected life situations, just like any human being. The clinic apologizes for any inconvenience or delays should this occur. The clinic will do their best to notify me in a timely manner should my appointment be delayed or changed. (*Your understanding and patience is appreciated.*)

Photography, Audio and Video Recording Policy

Audio and video recording of any kind is not permitted within the premises of the practice location.

Photography by patients, patient's families or patient's friends are not allowed in any common area including but not limited to the waiting room, hallways, and x-ray room. Photography by patients, patient's families or patient's friends is only allowed of that patient in treatment rooms with patient's verbal consent. Video recording or photography by patients, patient's families or patient's friends of other patients or Dr Webb Foot & Ankle Clinic employees is not permitted.

Treatment Policy

I understand I should follow the instructions given by my physician. Non-compliance or lack of proper follow-up leads to problems and complications that can be prevented. Compliance and appropriate feedback is crucial for successful treatment.

Communication Policy

If I have any questions, I will call (970) 460-6575. Even though our electronic health record software has the messaging ability, the clinic does not read or respond to the electronic messages generated by the system.

Mutual Respect Policy

The clinic staff performs tasks to the best of their ability. They make a sincere effort to treat every patient with respect and professionalism. I will treat all members of the clinic staff with the same courtesy I would expect from them. The clinic reserves the right to terminate any patient who they feel has violated this policy.

By signing this form, I acknowledge and agree to the *clinic policies*.

Patient name (print): _____

Signature: _____ Date: _____

Relationship to Patient (if minor or incapacitated): _____

Please list all medications you are currently taking:	For what purpose?

Any known drug allergies? **NO**

If YES, please complete below:

Name of drug:	What reaction(s) did it elicit?

Please print your name here

Today's date

Thank you!