Patient Information

671 E. Riverpark Ln. Ste. 110
Boise, ID 83706
208 387-0900
Fax 208 345-5883

Park Center Foot & Ankle Clinic

Doctor of Podiatric Medicine & Certified Surgeon

Randy E. Lowe, DPM

Visit Date:	Have you been seen in our office before? ☐ No ☐ Yes — Approx. Date:

PATIENT INFORMATION

Last Name	First Name	Middle	DOB / /	Age	Sex ☐ M ☐ F
Street Address	City	State	Zip		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Other
Mailing Address	City	State	Zip		
Email Address		Social Security No.			
Home Phone ☐ Preferred ( )	Cell Phone ☐ Preferred ( )	Work Phone ☐ Preferred ( )			
Employer	Occupation	Address	City, State, Zip		

IN CASE OF EMERGENCY

Local friend/relative	Relation	Cell Phone	Work Phone

PARENT/LEGAL GUARDIAN INFORMATION ***(Required only if patient is under 18 years old)***

Guarantor Name	SS#	Sex ☐ M ☐ F	DOB / /	Age
Email Address	Best Contact # ☐ Home ☐ Work ☐ Cell		Can we leave a message? ☐ Yes ☐ No	
Street Address	City, State, Zip		Relation	

CHOSE CLINIC ☐ Location ☐ Insurance Plan ☐ Website ☐ Other: **BECAUSE** _____	**REFERRED** ☐ Insurance ☐ Physician ☐ Other **BY** _____

INSURANCE INFORMATION

Primary Ins. Co			**Employer**
	Policy #		**Group #**
	Policyholder	**DOB**	**Relation** ☐ Self ☐ Spouse ☐ Dependent
Secondary Ins. Co			**Employer**
	Policy #		**Group #**
	Policyholder	**DOB**	**Relation** ☐ Self ☐ Spouse ☐ Dependent

ALL PATIENTS PLEASE READ & SIGN

I authorize payment of medical benefits from Medicare, Medigap, private and/or group insurance be made on my behalf to Park Center Foot & Ankle Clinic for any services or supplies furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration or my insurance company any information needed to determine benefits for related services. I also take responsibility for payment of charges, regardless of payment or denial of payment from my insurance company.

_____ Patient or Patient Representative

_____ Relationship (if not self)

_____ Date

Current Concerns

671 E. Riverpark Ln. Ste. 110
Boise, ID 83706
208 387-0900
Fax 208 345-5883

Park Center Foot & Ankle Clinic

Doctor of Podiatric Medicine & Certified Surgeon

Randy E. Lowe, DPM

Patient Name _____ Visit Date _____

Describe Issue											
Circle Area Affected	**Foot**	**Toes**					**Other**				
	Right	Great	2nd	3rd	4th	5th	Nail	Heel	Arch	Ball	Side
	Left	Great	2nd	3rd	4th	5th	Nail	Heel	Arch	Ball	Side

	Top	Joints	Ankle	Entire					
	Top	Joints	Ankle	Entire					

Quality	☐ aching	☐ stabbing	☐ dull	☐ occasional	☐ worsening	**Severity**	Pain level ___/10
	☐ burning	☐ throbbing	☐ superficial	☐ frequent	☐ improving		☐ no pain ☐ mild
	☐ gnawing	☐ sharp	☐ deep	☐ constant	☐ not changing		☐ moderate ☐ severe

How long has it bothered you? _____ Days _____ Weeks _____ Months _____ Years

Timing	☐ cannot identify ☐ acute ☐ chronic	☐ abrupt ☐ gradual ☐ morning	☐ daytime ☐ nighttime ☐ recurrent	☐ rare ☐ occasional ☐ intermittent episodes lasting: ☐ other:

Improves With		
☐ nothing helps	☐ elevation	☐ brace
☐ sitting	☐ exercise	☐ crutches
☐ standing	☐ stretching	☐ cane
☐ lying down	☐ limited weight bearing	☐ wheelchair
☐ position change	☐ PT/OT	☐ walker
☐ heat	☐ OTC medication	☐ removal of shoes
☐ ice	☐ narcotics	
☐ rest	☐ NSAID's	
☐ Other:		

Worse with	
☐ cannot identify	☐ morning
☐ sitting	☐ daytime
☐ standing	☐ nighttime
☐ lying down	☐ cold weather
☐ walking	☐ barefoot
☐ lifting	☐ flat shoes
☐ range of motion	☐ wearing heels
☐ weight lifting	
☐ Other:	

Associate Symptoms	☐ weakness	☐ tingling	☐ redness	☐ instability	☐ drainage	☐ other
	☐ numbness	☐ swelling	☐ warmth	☐ radiation down the leg	☐ bleeding	_____

PREVIOUS FOOT SURGERIES/PROCEDURES & YEAR ☐ None

PRIOR IMAGING

☐ None
☐ x-ray ☐ MRI
☐ labs ☐ ultrasound

Prior ☐ None	comments:	☐ did not help ☐ helped a little	☐ temporarily ☐ significantly

Other Treatments ☐ None	☐ orthotics ☐ night splint ☐ physical therapy ☐ other	comments:	☐ did not help ☐ helped a little ☐ temporarily ☐ significantly

Patient History

671 E. Riverpark Ln. Ste. 110
Boise, ID 83706
208 387-0900
Fax 208 345-5883

Park Center Foot & Ankle Clinic

Doctor of Podiatric Medicine & Certified Surgeon

Randy E. Lowe, DPM

Patient Name _____ Visit Date _____

Primary Care Physician		Last Visit	
Preferred Pharmacy		Address/Cross Road	

Medication Allergies ☐ No Known Allergies
☐ Latex ☐ NSAIDS ☐ Adhesives ☐ Aspirin ☐ Codeine ☐ Iodine/betadine
☐ Novocaine ☐ Penicillin ☐ Anesthesia ☐ Sulfa ☐ Other:

Diabetes ☐ No ☐ Yes
Diagnosed _____ (approximate year)
Type ☐ 1 ☐ 2 ☐ Pre-Diabetic
Treatment (√ all that apply) ☐ Insulin ☐ Oral Medication ☐ Lifestyle
Controlled (Acceptable A1C) ☐ Yes ☐ No ☐ Unknown
Related Issues ☐ Neuropathy/Nerve Pain ☐ Ulcer History ☐ Slow Healing
Managed by ☐ Primary Care Provider ☐ Other:

Other Contributing Problems ☐ Chronic Pain Syndrome ☐ Fibromyalgia ☐ RA ☐ Other:

Indicate family history of the following ☐ **NONE**	Father	Mother	Sister	Brother
Arthritis				
Cancer				
Diabetes				
Foot Deformity				
Heart Disease				
Hypertension				
Poor Circulation				

Tobacco
☐ Never
☐ Quit _____ (approx. year)
☐ Smoke approx. _____ # of packs per week

Alcohol
☐ Never
☐ Occasionally (less than 1 drink/week)
☐ Moderate (less than 3 drinks/day & 7/week)
☐ Heavy

Weight_____
Height_____

Pregnant
☐ No ☐ Yes, I am currently pregnant _____ weeks

Any Previous Surgeries ☐ **No Past Surgeries** ☐ **List Attached**

Year	Procedure

Past Health History Any history of the following: ☐ None

☐ AIDS/HIV	☐ Edema	☐ Heart Disease	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Anemia	☐ Fibromyalgia	☐ Hepatitis	☐ Lung Disease	☐ Sciatica
☐ Arthritis	☐ Foot Problems	☐ Hernia/Specify	☐ MRSA	☐ Sleep Apnea
☐ Artificial Joints	☐ Frost Bite	☐ Hypertension	☐ Neuropathy	☐ Stroke
☐ Bleeding Disorder	☐ GERD/Heartburn	☐ Insomnia	☐ Organ Transplant	☐ Thyroid Problems
☐ Cancer	☐ Gout	☐ Kidney Disease	☐ Osteoporosis	☐ Tuberculosis
☐ Diabetes	☐ Headaches	☐ Leg/Foot Ulcers	☐ PVD	☐ Varicose Veins

Comments:

Medications

Include OTC, Prescriptions, Supplements & Vitamins

671 E. Riverpark Ln. Ste. 110
Boise, ID 83706
208 387-0900
Fax 208 345-5883

Park Center Foot & Ankle Clinic
Doctor of Podiatric Medicine & Certified Surgeon

Randy E. Lowe, DPM

____
Patient Name

☐ I do not take any medications regularly ☐ List attached

Medication *(Name)*	Dose *(mg)*	Form *(tab, capsule)*	Route *(by mouth, inhale)*	Schedule *(1 tab/day, 1 tab twice daily, every 8 hrs)*

671 E. Riverpark Ln. Ste. 110
Boise, ID 83706
Tel 208.387.0900
Fax 208.345.5883

Park Center Foot & Ankle Clinic

Board Certified Physician & Surgeon of the Foot

Randy E. Lowe DPM

Release of Medical Records

_____
Patient's Name

_____
Date of Birth

I request and authorize the release of healthcare information to/from Dr. Randy Lowe to include:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ Other:

Unless otherwise specified this includes authorization to include the release of any records involving drug, alcohol, and mental health treatment in regards to the person listed above.

_____ _____
Signature of Patient/Patient's Representative Date

Park Center Foot & Ankle Clinic
Randy E. Lowe, DPM

Patient Name _____ DOB _____ Visit Date _____

Office Policies

As the patient, You have both the right and obligation to make decisions concerning your health care. We are disclosing our policies to you up front so that we may avoid any misunderstandings in the future. It is our desire to provide medical services at an affordable price.

_____ Initial

Cancellations & "No Show" Patients
As a business we are not able to absorb the cost of cancellations with less than 24 hour notice and "no show" patients. Therefore, patients will be assessed $25 for missed appointments without proper notice (*incase of an emergency fees can be waived*). This fee must be paid prior to receiving further treatment.

_____ Initial

Credit & Billing
I hereby assign my insurance benefits to be paid directly to the healthcare provider and authorize the release of medical information that may be required to process my claim.

We expect to collect your co-payment at the time of your office visit. We accept cash, Visa or Master Card debit/credit cards. Most everyone is required by your insurance company to pay a co-payment that has been predetermined by insurance companies and it is your responsibility to know. We will bill insurance on a timely basis. If you do not have insurance we are sensitive to your individual financial constraints. In either case, it is critical for you to stay in contact with our billing office.

+ Either a flat rate of $20-$40 per visit co-payment or payment of 10 to 20% of the total charges will be expected. Full payment is expected at time of service if the deductible has not been met.

+ If you have no insurance, our office has established a cash price for all services provided by Dr. Lowe. Payment will be expected in full at the time of service unless otherwise discussed.

We will send you a statement to your last known address. You will receive only two statements after your insurance has paid their portion. If there is a balance on your account and you have not made payment arrangements with our billing office, your account will be referred to a professional collection agency which will adversely affect your credit.

_____ Initial

Medications
I authorize my provider to obtain/have access to my medication history.

_____ Initial

Consent to Call
I authorize my provider's office to contact me by my mobile phone number.

_____ Initial

Acknowledgement of Receipt of Notice of Private Practices
I acknowledge that I was provided or shown a copy of the notice of private practice and then I have read or had the opportunity to read, if I so chose, and understand the notice. I understand that Dr. Lowe may collaborate with other health care providers to coordinate, manage and provide health care to me, and I consent to Dr. Lowe sharing patient's health information and records for the purpose of treatment, payment or operations as defined by HIPAA.

I have read and understand these policies. I understand I am financially responsible for the payment of medical charges incurred on my behalf at Park Center Foot & Ankle Clinic whether or not my insurance company pays or denies my claims. I understand it is my responsibility to ask questions or request additional information regarding these policies.

_____ Patient or Patient's Representative's Signature

_____ Date

_____ Relationship (if not self)