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:_____

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Clinic Policies

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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) 460-6575 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!