

Podiatry Center of Idaho

Gary J. Millward, D.P.M. • Scott A. Graviet, D.P.M.

6051 N. Eagle Road, Boise, Idaho 83713

Telephone (208) 938-4670, Fax (208) 938-4675

PATIENT INFORMATION SHEET

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City / State: _____ Zip: _____

Phone #: (____) _____ - _____ Cell #: (____) _____ - _____ SEX: M F

Birthdate: ____ - ____ - ____ SS#: ____ - ____ - ____ E-MAIL: _____

Family Physician: _____

EMPLOYER

Name: _____

Street Address: _____ City / State: _____ Zip: _____

Work Phone #: (____) _____ - _____ EXT: _____

RESPONSIBLE PARTY

Last Name: _____ First Name: _____

Street Address: _____ City / State: _____ Zip: _____

Phone #: (____) _____ - _____ Birthdate: ____ - ____ - ____

Employer: _____ Phone #: _____

Relationship to Patient: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____

Relationship to Patient: _____

SOURCE OF REFERRAL

Family/Friend Phonebook Sign/Billboard Physician Name: _____
 Radio Newspaper Other: _____

Podiatry Center of Idaho

Gary J. Millward, D.P.M. • Scott A. Gravier, D.P.M.

6051 N. Eagle Road, Boise, Idaho 83713

Telephone (208) **938-4670**, Fax (208) **938-4675**

Welcome to the Podiatry Center of Idaho!

We are pleased to receive you as a new patient in our office. We will work closely with you to ensure maximum benefit for the proper resolution of your podiatry concerns.

Please review the following information regarding our office policies.

Our policy is payment upon completion of each visit or service. If you have insurance, you will be expected to pay any co-payments, co-insurance amounts or any amounts subject to your deductible. We accept most insurance plans and we participate in the managed care programs of the following insurance companies: Blue Cross of Idaho, Regence Blue Shield of Idaho, Idaho Physicians Network, Primary Health and The Affordable Network.

Your insurance policy is a contract between you and your carrier. For your convenience, we will submit your claims to your primary insurance company. If your insurance carrier has not paid your account in full within thirty days of billing, **we will require that you pay the balance.**

Please be prepared to provide our office with all pertinent insurance information. **If you do not have this information with you on your first visit, you will be required to pay in full for services received.**

IF YOU DO NOT HAVE MEDICARE, PLEASE READ AND SIGN THE FOLLOWING STATEMENT:

I request that payment of authorized insurance benefits be made either to me or on my behalf to the Podiatry Center of Idaho for any services furnished me by the participating physicians.

Signature: _____ **Date:** _____

MEDICARE PATIENTS - PLEASE READ AND SIGN THE FOLLOWING STATEMENT:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Podiatry Center of Idaho, PLLC, for any services furnished me by the Podiatry Center of Idaho.

Signature: _____ **Date:** _____

Welcome to Our Practice!

Name: _____ Date: _____

Main Reason for this visit (chief complaint):

Family Medical Doctor: _____ Date of last visit: _____

Is your problem related to: Work Accident Auto Other

Date of Injury: _____

Drug Allergies: No Yes If yes, please list _____

Describe below the symptoms/reactions you had from taking the above-mentioned drug

Family Medical History

Please list age, diseases, and if deceased, the cause of death

Father: _____

Mother: _____

Siblings: _____

Current Medications

Please list name of current medications

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Previous Hospitalization / Surgeries

Type or Reason for Hospitalization / Surgery / Year Performed (Approximately)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please check "Yes" or "No" to indicate conditions that you have had or have at present

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Total Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (specify)
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/> Insulin <input type="checkbox"/> Adult <input type="checkbox"/> Juv	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Difficulty			
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Skin Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis			

Patient Social History

Marital Status: Single Married Divorced Widowed

Use of Alcohol: Never Social Mild Moderate Heavy

Exercise Habits: Never 1 – 3 times per week 4 x per week or more

Use of drugs: Never Type/frequency: _____

Use of tobacco: Never Previous but quit Current pack/day _____

Occupation: _____

Authority to Treat

I hereby give my permission to Dr. Gary J. Millward and/or Dr. Scott A. Graviet to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature: _____ Date: _____