Dr. Esther Barnes, DPM FACFAS
Step Ahead Foot & Ankle Clinic, P.C.
175 Commons Loop, Suite 400
Kalispell, MT 59901
(406) 755-2818

Dear _____,

Welcome to Step Ahead Foot & Ankle Clinic, P.C! You have made an excellent choice for your podiatric (foot and ankle care) needs. It is our hope that this pre-visit information will save time for you at your first visit. **Please plan to arrive 30 minutes early to complete registration. Please note, if you are unable to do so you will be asked to reschedule.**

If you'd rather complete your medical history and demographic information online, please call the office at 755-2818 and ask to set-up a "patient portal" account that will allow you to do so. This will also allow you to access to your medical records and statements online as well. If not, please complete the enclosed patient information form as thoroughly as possible and bring it with you to your appointment with Dr. Esther Barnes on _____ at _____. **If you are unable to keep this appointment, please call the office at the above number at least 24 hours in advance.** Failure to do so may result in missed appointment fees.

Step Ahead Foot & Ankle Clinic, P.C. currently participates in several insurance plans, including Medicare. If you are covered by Medicare, please bring your Medicare card with you to your appointment. If you have a supplement to Medicare and would like our office to file that insurance for you as well, please bring that insurance card, too.

If you are unsure if we accept your specific insurance plan, please contact the office. Our office staff will attempt to contact your insurance company prior to your visit to verify benefits and obtain deductible and copayment amounts. **However, it is your responsibility to understand your individual health benefits. All co-payments will be collected before services will be provided. Cash paying patients will be expected to pay at the time of service.** Remember to bring your insurance card with you to your appointment.

We look forward to meeting you and taking care of your foot & ankle care needs. Enclosed in this mailing you should find directions to the office; If you have any questions, however, please feel free to call the office at (406) 755-2818.

Sincerely,

Dr. Esther Barnes and staff of
Step Ahead Foot & Ankle Clinic, P.C.

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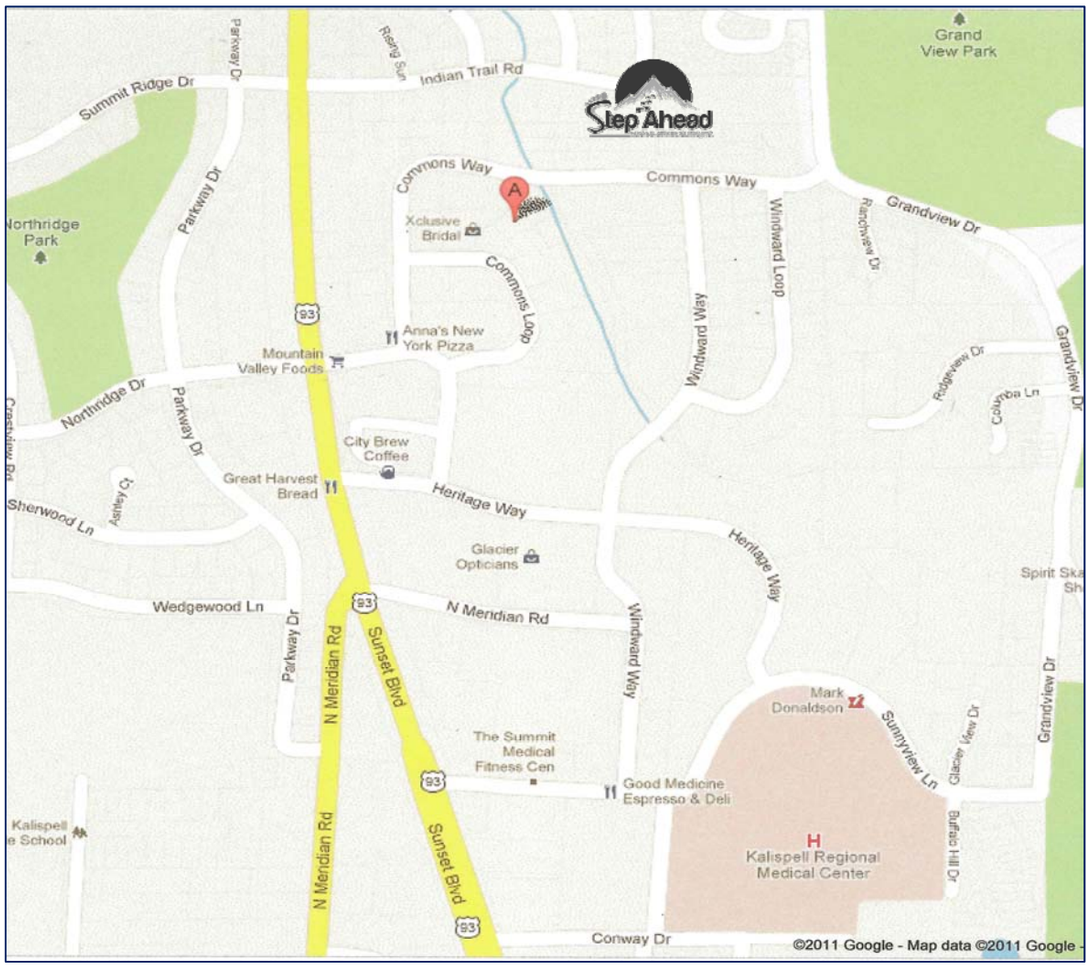
Directions to Step Ahead Foot & Ankle Clinic, P.C.:

1. Turn off Hwy 93 North at the Blue Cow Car Wash onto Commons Way (take a right if coming from the south, left if coming from the north).
2. Turn left onto Commons Loop (just past Glacier Bank).
3. Take a right into Professional View office complex parking lot. (Dermatology Associates is located downstairs).
4. Our office is located upstairs in Suite 400. Elevator is available.
5. Our address is 175 Commons Loop, Suite 400 Kalispell.



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Patient Information

Patient First Name_____MI_____ Last Name_____

Patient Home Street Address_____ Apt#_____

Patient Mailing Address (if different)_____

City_____ State_____ Zip _____

Patient Home Phone#_____ Cell Phone#_____

Patient email address_____ Preferred contact: □ home phone □ cell □ email

Patient Date of Birth_____ Age_____ Social Security Number _____

Patient Height_____ Weight_____ Shoe Size_____ □ Male □ Female

Emergency Contact Name_____Phone_____Relationship_____

Pharmacy_____ Medical Doctor / PCP _____

If patient is a minor - provide Name of parents or guardian _____

Address of parents or guardian _____

Home Phone#_____ Cell Phone#_____

Payment & Insurance Information

Please present your insurance card and driver's license (or other form of identification) upon arrival.

Name of Insurance _____ □ Check here if no health insurance

Insurance ID _____ Group # / Name_____

Full Name of Insured _____Relationship to Patient_____

Insured SS#_____Insured Date of Birth _____

Insured Employer _____

Secondary Insurance _____ Group # / Name_____

According to my insurance, I am responsible to pay a Co-Pay Amount $_____ Deductible Amount $_____

Person responsible for finances (if different from card holder): _____

Payment today will be made by: □Cash □Check □Visa □Master Card □American Express □Discover

My insurance requires a referral from my PCP before I see a specialist. □Yes □No

Referral Information

We appreciate your referrals! Who may we thank for referring you to our office?

Name_____

Address_____

Is this person your: □Family Member □Friend □PCP □Other Specialist

Other Referral Sources: □Internet Search □Insurance Plan Website □Phone Book □Newspaper Ad □ Website

Name: _____

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Podiatric History

Have you ever been to a podiatrist / other foot specialist before? ☐Yes ☐ No

What is your **chief foot complaint** for which you came to be treated today?_____

_____

_____

When did it begin? _____

Did you receive treatment for this condition? ☐Yes ☐No

If so, what type?_____

_____

Circle the **degree of pain** you are currently experiencing: **Minimal** 1 2 3 4 5 6 7 8 9 10 **Severe**

Have you ever had any of the following **foot conditions**?

☐ Ankle Instability	☐ Arthritis	☐ Back Pain	☐ Blisters	☐ Bone Spurs	☐ Bunions
☐ Burning Feet	☐ Corns/Calluses	☐ Diabetic Eval	☐ Flat Feet	☐ Fracture	☐ Fungal Infections
☐ Gout	☐ Hammertoes	☐ Heel Pain	☐ Hip Pain	☐ Infections	☐ Ingrown Toenails
☐ Joint Pain	☐ Knee Pain	☐ Limb Length Discrepancy		☐ Neuromas	☐ Numbness or tingling
☐ Plantar Fasciitis	☐ Postural Fatigue		☐ Pronation	☐ Shin Splints	☐ Sprains
☐ Sweating/Odor	☐ Tendonitis	☐ Ulcers	☐ Tired feet	☐ Warts	

Name of MD / Family Physician _____Date of Last Visit _____

Medical History

Have you ever been treated for any of the following conditions? Please check all that apply to you.

_____Acid Reflux	_____Epilepsy	_____Hyperthyroidism	_____Phlebitis
_____Anemia	_____Fatigue	_____Hypothyroidism	_____Poor Circulation
_____Arterial Disease	_____Fibromyalgia	_____Irritable Bowel	_____Respiratory Dis.
_____Arthritis	_____Headaches	_____Kidney Problems	_____Rheumatic Fever
_____Asthma	_____Heart Condition	_____Liver Disease	_____Seizure Disorders
_____Bleeding Disorders	_____Hepatitis	_____Nervous Disorder	_____Stomach Ulcers
_____Cancer	_____High Cholesterol	_____Joint Pain	_____Stroke
_____Depression	_____HIV/Aids	_____Parkinson's	_____Varicose veins
_____Diabetes	_____Hypertension		

Family History

Place check mark next to status/medical history of mother and father.

Father: ☐ Living ☐ Deceased ☐ Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Condition ☐ Stroke ☐ Mental Disorder ☐ Cancer ☐ Unknown

Mother: ☐ Living ☐ Deceased ☐ Unknown

☐ Diabetes ☐ Hypertension ☐ Heart Condition ☐ Stroke ☐ Mental Disorder ☐ Cancer ☐ Unknown

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Social History

Do you currently use: Cigarettes or Tobacco? ☐ Yes ☐ No ☐ Quit

If yes, every day? _____ How many packs / day? _____

If quit, when? _____ years _____months

Alcohol use? ☐ Yes ☐ No If yes, quantity _____ daily _____ weekly

Patient Occupation_____ Employer Name_____

Medications

Patient's or Authorized Person's Rx Consent

Do you give consent to grant permission to view prescription history from external sources?

If yes, please sign here _____
Patient/Guardian Signature

Name of Medication / Vitamin	Dose	Times/Day	How Long

Allergies: _____

_____

Prior Surgeries & Hospitalizations Please check here if you deny past: ☐ surgical history and/or ☐ Hospitalizations

Surgeries / Hospitalizations	Year	Reason

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Review of Systems

Please circle all that apply.

GENERAL	Change in appetite	Chills	Fatigue	Fever	Headache	Lighthead-edness	Night Sweats	Weight Gain / Loss
EAR,NOSE, THROAT	Sore throat	Decreased hearing	Decreased sense of smell	Difficulty swallowing	Dry mouth	Ear Pain	Nosebleed	Ringing in ears
RESPIRATORY	Chest pain	Cough	Hemoptysis	Pain with inspiration	Shortness of breath	Sputum production	Wheezing	
CV (HEART)	Chest pain at rest	Chest pain with exercise	Difficulty lying flat	Dizziness	Fluid accumulati on in legs	Irregular heartbeat	Racing Heart	Shortness of breath
GI (STOMACH/ INTESTINE)	Abdominal pain	Blood in stool	Vomiting	Constip-ation	Decreases appetite	Diarrhea	Difficulty swallowing	Heartburn
GU (URINARY)	Abdominal pain / swelling	Blood in urine	Difficulty urinating	Frequent urination	Pain in lower back	Painful urination		
ENDOCRINE	Cold intolerance	Difficulty sleeping	Dizziness	Excess sweating	Excessive thirst	Frequent urination	Heat intolerance	Weight loss
HEMATOLOGY	Breast lump	Dizziness	Easy bruising	Fever	Groin mass	Prolonged bleeding	Recent transfusion	Swollen glands
VASCULAR	Cold extremities	Decreased sensation in legs	Cramping in legs after exercise	Painful legs	Foot ulcerations			
NEURLOGIC	Balance difficulty	Lack of Coordinati on	Difficulty speaking	Dizziness	Tingling / numbness	Gait abnorm-alities	Headaches	Seizures
DERM (SKIN)	Acne	Blistering of skin	Discolor-ation	Dry skin	Eczema	Hives	Itching	Keloid formation
MUSCULO-SKELETAL	Joint stiffness	Leg cramps	Muscle aches	Painful joints	Sciatica	Low back pain	Hip pain	Weakness

Signature on File & Permission to Treat

- I understand that the information provided on this form is true and correct to the best of my knowledge.
- I request that payments of authorized benefits be made on my behalf for any services furnished by Step Ahead Foot & Ankle Clinic PC.
- I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.
- I recognize my financial obligation of any coinsurance, copays or deductibles and non-covered services that may be required.
- I hereby give permission to Step Ahead Foot & Ankle Clinic and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Patient or Authorized Signature: _____

If not patient, state relationship _____Date_____