RANDY GARR, DPM
MATT STODDARD, DPM

1355 North University Avenue
Suite 125, Provo UT 84604
Office: (801) 374-3010
Fax: (801) 377-2426

Patient Information

Please print the following information
All information is confidential and important for our files and your health.

Patient Name (legal) : ____________________________ **Age**: ____ **Sex**: M / F **Date of Birth**:________
Home Address:____
City:____ **State**:_____ **Zip**: _____________
Home Phone: ____________________________________ **Cell Phone**:______________________________
Email Address: __________________________ **Social Security Number**: __________________________
May we leave messages on your home or cell phone answering machine?
Circle one: YES / NO
Would you prefer a reminder in another method?
Circle one or both: TEXT / EMAIL
Marital Status: Single Married Divorced Widowed
Race : ____
Employer name/ School name: ____
Please list your family doctor: ____
Preferred Pharmacy: ____

Insurance Policy Holder Information:
Name: ____________________________________ **Relationship to Policy Holder:** ___________________
Birth date:__________________ **Address :**____
Home Phone:_____________________________ **Cell Phone:** ____________________________________

How did you hear about us (Circle all that apply)?

Google Summit Web Site Insurance Company Doctor Referral Family/Friend Referral Healthgrades

Other: ____

Does this insurance require a referral? Yes / No
<u> If yes, you must obtain the referral prior to seeing the doctor today! **</u>**

Spouse's name or name of nearest relative (or parent if you are under 18):
Name: ______________________________ **Relationship:** ____
Phone: _____________________________ **Address**: ____

What is the nature of your foot complaint? ____

____

What have you done for this condition? ____

____

When does it hurt the most? ____

Approximately when did the condition start? ____

Are you generally in good health? Yes No Shoe size_______

If female, are you now pregnant? Yes No Weight_________ Height _______________

Past medical history – Do you have or have you had any of the following:

	Yes	No		Yes	No
Diabetes Type 1	__	__			
Diabetes Type II	__	__	Heart Disease / Heart Attack	__	__
Acid Reflux (GERD)	__	__	High Blood Pressure	__	__
Arthritis	__	__	Low Blood Pressure	__	__
Asthma	__	__	Nervousness / Anxiety	__	__
Back Problems	__	__	Rheumatic Fever	__	__
Deep Vein Thrombosis	__	__	Seizures / Seizure Disorder	__	__
Pulmonary Embolism	__	__	Skin Problems: __________	__	__
Cancer: ________________	__	__	Stroke	__	__
Depression	__	__	Thyroid Problems	__	__
Gout	__	__	Varicose Veins	__	__
Hay Fever	__	__	Other: __________________		
Hepatitis	__	__			

Allergies

	Yes	No		Yes	No
Penicillin	__	__	Aspirin	__	__
Local anesthetics	__	__	Iodine	__	__
Sulfa	__	__	Tape / Adhesives / Latex	__	__
Codeine	__	__	Other: ___________________________		

Please List the Medications (PLEASE INCLUDE DOSAGE) You Currently Take:

____

____

____

Previous Surgeries: (all surgeries - include dates if possible): ____

____

____

Family history (please circle if applicable and write in what family member and if they are still living):

Diabetes ____

High Blood Pressure ____

Heart Disease ____

Bleeding disorders ____

Anesthesia problems ____

Blood clots ____

Varicose Veins ____

Cancer: (what kind?) ____

Other: ____

Social history:

Have you ever smoked before? Yes / No If so, do you currently smoke? Yes / No

If yes, how many packs per day? ____________ How long? ___________

If you have quit, please indicate the date when:_____________________________________

Do you use any other tobacco products? Yes / No

If yes, how much?____

How often do you drink alcohol? Never Occasionally Moderately History of abuse

If yes, what kind?_________________________ How much?_____________________

Do you use caffeine? Yes / No

If yes, in what form? _______________________ How much? ____________________

Have you used recreational drugs? Yes / No If so, do you currently use recreational drugs? Yes / No

If yes, in what form? ______________________________________

What do you do for work? ____

Are you on your feet for the majority of your work day? Yes / No

I hereby authorize Garr Foot & Ankle, LLC. to furnish my designated insurance carrier all the information concerning my present illness or injury. I authorize benefits under this claim to be made directly to the physician.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING:

A) I agree that I am responsible for this debt regardless of my insurance and that I will pay any unpaid balance, in full, within 90 days of the date of billing. I agree to pay 18% interest per annum on the unpaid balance, compounded daily.
B) In the event that my account is not paid as agreed, I agree to pay a collection agency fee of 25% of my unpaid balance in addition to my balance, in the event that my account is delinquent.
C) If the account must be referred to an outside collection agency, and I have opted out of receiving a final notice for the delinquent account by text or email below, a letter via certified mail or priority mail will be sent. In sending this letter, a fee of up to $6.00 will be added on top of the 25% collection fee when the balance is reported, which I agree to pay.
D) In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney's fees and costs of court and agree to submit to the jurisdiction of the Third Circuit Court, Salt Lake City, State of Utah.
E) If any portions of a bill for the provider's services are disputed, I agree to submit myself to mediation or arbitration and will pay the costs incurred in doing so.

Signed: ____ **Date**: _______________

CONTACT OPTIONS: We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, you expressly authorize us to contact you by the telephone by sending text messages or e-mails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

Yes, I authorize this (initials) ________ No, I do not authorize this (initials)________

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

____ _______________________________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

____

Signature