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

SUMMIT
FOOT & ANKLE SPECIALISTS

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:**_____
Work Phone: _____**Email Address:** _____
Marital Status: Single Married Divorced Widowed
Race :_____
Employer name/ School name: _____
Social Security Number: _____
Please list your family doctor: _____ **Approximate date of last visit**: _____

Preferred Pharmacy: _____

Insured Information if dependent:
Name: _____
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 or Friend Referral

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: _____
Relation: _____ **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	__	__			
Acid Reflux (GERD)	__	__	Heart Disease / Heart Attack	__	__
Arthritis	__	__	High Blood Pressure	__	__
Asthma	__	__	Low Blood Pressure	__	__
Back Problems	__	__	Nervousness / Anxiety	__	__
Bleeding Disorder	__	__	Rheumatic Fever	__	__
Cancer: _____	__	__	Seizures / Seizure Disorder	__	__
Depression	__	__	Skin Problems: _____	__	__
Gout	__	__	Stroke	__	__
Hay Fever	__	__	Thyroid Problems	__	__
Hepatitis	__	__	Varicose Veins	__	__
			Other: _____		

Allergies

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

Please List the Medications 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? _____

What do you do for work? _____

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

PATIENT NAME: _____

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 40% of my unpaid balance in addition to my balance, in the event that my account is delinquent.
C) 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.
D) 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**: _____

SUMMIT
FOOT & ANKLE SPECIALISTS

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

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

ALSO, 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