Dry Creek Medical Center
Dr. John A. Sharp, D.P.M.
145 Inverness Drive East, Suite 220
Englewood, Colorado 80112
Office: 303.699.7325 | Fax: 1-844.270.0664

Today's Date_____ ☐Male ☐Female

Last Name_____ First Name_____

Mailing Address_____

City_____ State_____ Zip _____

Primary Phone #_____Secondary Phone #_____

Email Address_____ SSN Last 4_____ Birthdate_____

Age_____ Height _____ Weight _____ Shoe Size _____

Emergency Contact _____ Contact #_____

Pharmacy Name_____ Pharmacy Phone #_____

Pharmacy Address_____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD (S) TO THE RECEPTIONIST)

Primary Insurance_____ Relationship to Patient_____

Subscriber ID #_____Group Number_____ Copay_____

Name of Policy Holder_____ Policy Holder's Date of Birth_____

Secondary Insurance_____ Relationship to Patient_____

Name of Policy Holder_____ Policy Holder's Date of Birth_____

REFERRAL INFORMATION HOW DID YOU FIND OUT ABOUT US?

☐Insurance Company ☐Doctor _____

☐Website ☐Family Member/ Friend _____

GENERAL

Family Physician_____ Phone Number_____

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SOCIAL HISTORY

Occupation_____

Smoking Status ☐Current Every Day Smoker ☐Current Some Day Smoker
☐Former Smoker ☐Never Smoker

Smokeless Tobacco Use ☐Yes ☐No

Alcohol Use ☐None ☐Former Drinker ☐Occasional ☐Alcoholic

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed

Exercise ☐Doesn't Exercise ☐Daily Exercise ☐A Couple Times a Week ☐Once a Week

HISTORY OF PRESENT COMPLAINT (INSURANCE REQUIRES ALL PARTS TO BE FILLED OUT)

Please explain foot/ankle problems, what part of foot/ ankle:

_____

_____

☐Left ☐Right ☐Both

Quality ☐No Pain ☐Acute Pain ☐Chronic ☐Constant ☐Dull Ache
☐Feels Heavy ☐Improving ☐Intermittent ☐Numbing ☐Sharp
☐Stabbing ☐Stable ☐Throbbing ☐Tingling ☐Worsening

Severity ☐Mild ☐Moderate ☐Severe
☐1-Mild ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10-Severe

Duration X Days _____ X Weeks _____ X Months_____ X Years_____

Timing ☐Continuous ☐Day time ☐In the morning ☐Night time ☐Intermittent

Context Occurs ☐At Rest ☐At Work ☐When Standing ☐When Stressed
☐While Walking ☐With Activity ☐With Exercise ☐Other _____

Modifying Factors

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Relieved ☐Stopping Activity ☐When Cold Applied ☐When Heat Applied ☐With Activity
☐With Anti-Inflammatories ☐With Lying Down ☐With Pain Medication ☐With Rest
☐Other_____

Exacerbated ☐With Activity ☐With Eating ☐When Exercise ☐With Standing ☐While Walking
☐Other _____

Associated Signs and Symptoms ☐Fever ☐Itching ☐Redness ☐Swelling ☐Weakness ☐Pain
☐Other _____

Previous Treatment_____

MEDICAL HISTORY SELECT ALL THAT APPLY

☐No major illnesses or other prior medical conditions

☐Alcohol Dependency
☐Alzheimer's
☐Anemia
☐Arthritis_____
☐Artificial Joints_____
☐Asthma
☐Bleeding Disorders/ Blood Clots
☐Cancer_____
☐ Cataracts/ Lens Replacement
☐ Chemical Dependency
☐ Chemo/ Radiation Treatment
☐ Current Pregnancy
☐C-Section
☐Diabetes Type 1
☐Diabetes Type 2
☐Dialysis
☐Disk Herniation
☐Drop Foot
☐Endocrine/ Hypothyroidism
☐Eye, Glaucoma
☐GI- reflux GERD
☐Gout
☐Heart Arrhythmias (irregular heartbeat)
☐Heart Attack
☐Heart Disease
☐Hearing Loss
☐High Blood Pressure
☐Implants _____
☐Inflammatory
☐Kidney Failure
☐Kidney Stones
☐ Kyphosis (abnormal spine)
☐Liver Disease/ Hepatitis
☐Mental Illness
☐Menopause
☐Migraine Headaches
☐Neurological
☐Neuropathy, numbness
☐Osteoporosis (decreased bone mass)
☐Osteopenia (low bone mass)
☐Paralysis
☐Prostate
☐Tremors
☐Rheumatoid Arthritis
☐Seasonal Allergies
☐Sciatica
☐Scoliosis (spine curved side to side)
☐Short Limb
☐Sinusitis
☐Spinal Cord Injures
☐Spinal Disk Disease
☐Stroke/ TIA/ CVA
☐Ulcer- stomach/ esophagitis
☐Urinary Incontinence
☐Other_____
☐Other_____
☐Other _____

Hospitalization in the past 2 years? ☐ **Yes** ☐ **No** If so when/ what caused it?_____

FAMILY HISTORY SELECT ALL THAT APPLY AND RELATIONSHIP

☐ Unknown family history
☐ Not Known-Adopted
☐Alive and Well
☐Arthritis_____
☐Cataracts_____
☐Diabetes 2_____
☐Hypertension_____
☐Stroke_____
☐Heart Attack
☐Anemia_____
☐Alcoholism_____
☐Anxiety_____
☐Cancer_____
☒Diabetes 1_____
☐Hyperlipidemia_____
☐Kidney Disease_____
☐DVT (blood clot in leg)/ PE (blood clot in lungs)
☐Neuropathy

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☐Gout ☐Scoliosis

SURGICAL HISTORY PLEASE LIST ALL SURGERIES AND YEAR

☐Denies having prior surgeries performed

_____
_____
_____
_____
_____

ALLERGIES (MEDICATIONS/ TOPICAL ALLERGIES) PLEASE EXPLAIN ALLERGY REACTION BELOW

☐No Known Allergies	☐Hmg-Coa Reductase Inhibitors	☐Paroxetine Derivatives
☐ACE inhibitors	☐ Ibuprofen	☐Paxil
☐Adhesive/ Tapes	☐ Iodine	☐Penicillin
☐Anti- Inflammatory Meds	☐ Keflex	☐Percocet
☐Aspirin	☐Latex	☐Pravachol
☐Bactrim	☐Levaquin	☐Quinolones
☐Benadryl	☐Lipitor	☐Salicylates
☐Biaxin	☐Lisinopril	☐Sertraline Derivatives
☐Cefaclor	☐ Macrolides	☐Sulfa
☐Cephalosporins	☐Meperidine	☐Tetracycline
☐Cipro	☐ Metronidazole	☐Ultram
☐Codeine	☐ Monosodium Glutamate	☐Zestril
☐Darvon	☐ Morphine	☐Zocor
☐Demerol	☐ NSAIDS	☐Zoloft
☐Flagyl	☐Opioid Analgesics	☐Other_____

Please Explain_____

MEDICATIONS YOU ARE TAKING **please list all medications along with dose and reason why you are taking**

Medication/ Dose	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

REVIEW OF SYSTEMS PLEASE CIRCLE WHICH ONE (S) IF YES AFTER PRINTING

Constitutional: Do you have any fever, chills, headache, general tiredness or weakness?
☐ Yes ☐No _____
Eyes: Do you have any blurred vision, double vision, blind spots, glaucoma or eye problems?
☐ Yes ☐No _____
ENT: Do you have any chronic or persistent ear, sinus, or throat infections or problems?
☐ Yes ☐No _____
Cardiovascular: Do you have any history of chest pain/ angina, high blood pressure, heart murmurs?
☐ Yes ☐No _____
Pulmonary: Do you have any history of persistent cough, wheezing, shortness of breath, pneumonia?
☐ Yes ☐No _____
Gastrointestinal: Do you have any chronic nausea, vomiting, indigestion, heartburn, stomach pains?
☐ Yes ☐No _____
Musculoskeletal: Do you have any history of back, neck or joint pain or injury?
☐ Yes ☐No _____
Integumentary: Do you have any skin rashes, persistent itching or other skin problems?
☐ Yes ☐No _____
Neurological: Do you have any history of tremors, dizzy spells, numbness or tingling?
☐ Yes ☐No _____
Psychological: Do you have any history of depression, anxiety attacks, or suicidal thoughts?
☐ Yes ☐No _____
Endocrine: Do you have any history of excessive thirst, weight loss/ gain or too hot/ too cold?
☐ Yes ☐No _____
Hematological: Do you have any swollen glands, excessive bleeding or blood clots?
☐ Yes ☐No _____

SIGNATURE ON FILE- PERMISSION TO TREAT

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I request that payments of authorized benefits be made on my behalf for any services furnished me by Sharp Podiatric Medicine and Surgery, LLC. 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 co-insurance, co-pays or deductibles and non-covered services that may be required. I give permission to Sharp Podiatric Medicine and Surgery, LLC, to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

Patient Signature_____Date_____

PRIVACY STATEMENT

Sharp Podiatric Medicine and Surgery, LLC, will use and disclose your health information for the following purposes: to treat you, to assist other healthcare provider in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities, such as quality assessment, licensing, accreditation and training of students. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you have any questions, concerns or complaints regarding our privacy practice, please refer to the actual Notice of Privacy Practices provided to you for the person(s) whom you may contact.

Patient Signature _____Date_____

Authorization to Obtain Medication History

I, _____ hereby authorize Sharp Podiatric Medicine and Surgery, LLC. to obtain/ download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug to drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

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Date of Authorization _____

Print Name (Patient/Legal Representative or Parent/Legal Guardian:

_____

Signature (Patient/Legal Representative or Parent/Legal Guardian:

_____

FINANCIAL POLICY WE ACCEPT, VISA, MASTERCARD, AMERICAN EXPRESS & DISCOVER

Thank you for choosing us as your podiatric physicians. We are committed to your treatment being successful, as you, the patient, are our first and foremost concern. As part of our service, we try to contain the cost of health care. In an effort to do this, we have implemented a Financial Policy.

The following is a statement of our FINANCIAL POLICY which we request you read and sign prior to any treatment. To avoid any misunderstandings, please contact us should you have any questions about our policies.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have complete and accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. It is your responsibility to contact your insurance company regarding preauthorizations, obtaining required referrals, second opinions, etc. Failure to do so may reduce the amount of benefits paid by your insurance, and the balance will then become your responsibility to pay. All co-payments must be paid at the time of service.

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, please be prepared to fully cover the fees for each visit at the time of treatment.

PAYMENT: Payments for the balance due, co-payments, deductibles, etc., are due at the time of service and may be made by cash, check or credit card (Visa, MasterCard, American Express, Discover). There will be a $25.00 charge for returned checks. Delinquent accounts will be referred for collection at the discretion of the office manager.

MANAGED CARE PATIENTS/PRIVATE INSURANCE: If you are in a managed care plan (HMO, PPO, IPA) with whom we participate, we abide by our contract with them. In either managed care plans or private plans, we will bill your insurance company; however you are responsible for paying any co-pays, coinsurance and deductibles required by your plan at the time of treatment.

MEDICARE PATIENTS: We accept assignment for Medicare; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any co-payments, which are usually 20% of the allowed amount for an item or service.

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MINOR PATIENTS: The adult or the parent (custodial guardian) accompanying a minor is responsible for payment of services. For unaccompanied minors, non-emergency treatment will be denied unless prior authorization from the parent or guardian has been made for the charges and treatment. Young adults (age 18 & over) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs this financial agreement, regardless of insurance coverage.

MISSED APPOINTMENTS: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

Please complete the following items:
What is your co-payment per visit: $_____
What is your insurance annual deductible: $ _____ How much of the deductible is current (not yet paid): $_____ (if you are not sure what your current (not yet paid) deductible is, please call your insurance company prior to your visit.)Please be prepared to pay your co-payment and any charges within your current deductible at the time of your visit.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due.

Patient Signature _____Date_____

OFFICE PROTOCOL

Welcome to the office Dr. John Sharp, we and the staff are very pleased to have you as a patient and hope you will receive high-quality treatment. We understand that your foot or ankle issue may be significant enough to interfere with your lifestyle and we will be very cognizant of your time. We recognize that you may be in pain and very frustrated with your situation and we hope to make this process as easy and pleasant as possible. We would like to cover a few items before we started.

Financial surprise or misunderstandings are the most common reasons for frustration. Please let us know as soon as an issues develops so that we can be very clear open and transparent to help avoid misunderstandings.

Definition of covered: When the staff uses the word "covered" it means that this item; whether a procedure or a piece of medical equipment is normally paid by your insurance company. However, even with insurance coverage, remaining fees after co-insurance and deductibles will apply to the patient. Therefore even though the item is covered, you may still have a bill.

Deductible: The deductible is an amount of money that is to be paid by the patient before any insurance benefits will be reimbursed. This means that the office will collect any charges to the patient at the time of service until this amount is reached. Please understand your deductible and how much has been met currently.

Co-Insurance: This is a percentage that some insurances do not pay and will require the insured patient to reimburse the physician or facility. A common co-insurance is either 10% or 20% and this varies significantly between specific procedures or medical equipment that is provided.

Co-pay: This is the amount your insurance will ask you to pay at each office visit and is due when you check in the office. You cannot be seen unless this fee is paid.

Late for appointment: We try to stay on time, but many times is not possible. This is made worse by patients being late for their appointment time. If you are greater than 20 minutes late, we may be able to work you into the schedule later in the day or we may ask you to reschedule. The new patient intake forms take about 20-30 minutes. If you are a new patient and have not filled out the intake forms by your appointment time, we may also ask you to reschedule.

Missed Appointments: Please help us serve you better by keeping scheduled appointments. If it is necessary to cancel, please call our office 24 hours in advance. This allows us to accommodate our other patients. We reserve the right to charge for missed appointments.

Orthotics: Prescription arch supports are designed to help manage the mechanical movement and motion of your foot. We use these regularly for treatment of many maladies. They are commonly not paid for by insurance companies and generally cost $350-400.

Cell phone: Please be courteous and turn your cell phone ring tone off. Innumerable times during office appointments, cell phone calls interrupt the evaluation and treatment process. If you are speaking on the phone during an office appointment Dr. Sharp will bypass your appointment until you are finished with your phone call.

Medical records: The office owns the medical record. It is not the property of a patient. The original copy must always stay in possession of the office. As a patient you may have access to your medical records and purchase copies per the fee schedule set by the state of Colorado. We require a signed waiver and request 2 weeks' notice.

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Routine foot care: This implies callused trimming and nail care. Trimming of nails and calluses are not normally covered by all insurance companies, especially Medicare. There is a fee of $45 payable at the time of service for callus and nail care. If you require the service please let the staff know ahead of your scheduled appointment as we use a pedicurist for this process. Dr. Sharp does not normally trim calluses or nails.

Common courtesy: It goes without saying that you are in a professional office and we expect you and your family to behave accordingly. Please use professional behavior at all times.

Many common foot ailments do not improve one single treatment and may require several weeks or months for improvement. Several different modalities may be needed depending upon the severity and the condition. Be prepared that multiple visits may be needed for diagnostic testing and possibly more than 1 treatment.

Medication refills: We try to refill PRN and daily use medication over the phone and we will ask you to be seen by physician relatively routinely. If you have not been seen within one year, your prescription will not be refilled. We ask gout patients to return every 6 months for labs and refills.

Lab testing, MRIs, and pathology reports: These imaging and testing results take time to be performed and to be reported back to our office. These will be interpreted by our staff and we will call you as soon as possible, and therefore we ask for your patience. Please allow 1 week for follow up on non-urgent results and performing the test. Obviously we will be in contact with you immediately for more serious results.

Patient Signature _____Date_____