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.
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.
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________________________________________________ Group # / Name____________________________
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: ____________________________________________
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
- Anemia
- Arterial Disease
- Arthritis
- Asthma
- Bleeding Disorders
- Cancer
- Depression
- Diabetes
- Epilepsy
- Fatigue
- Fibromyalgia
- Headaches
- Heart Condition
- Hepatitis
- High Cholesterol
- HIV/AIDS
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Irritable Bowel
- Kidney Problems
- Liver Disease
- Nervous Disorder
- Numbness or tingling
- Parkinson's
- Poor Circulation
- Respiratory Dis.
- Rheumatic Fever
- Seizure Disorders
- Stomach Ulcers
- Stroke
- Varicose veins

Family History

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

<table>
<thead>
<tr>
<th>Father:</th>
<th>Living</th>
<th>Deceased</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Hypertension</td>
<td>Heart Condition</td>
<td>Stroke</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother:</th>
<th>Living</th>
<th>Deceased</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Hypertension</td>
<td>Heart Condition</td>
<td>Stroke</td>
</tr>
</tbody>
</table>
**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

<table>
<thead>
<tr>
<th>Name of Medication / Vitamin</th>
<th>Dose</th>
<th>Times/Day</th>
<th>How Long</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allergies:** ________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Surgeries / Hospitalizations</th>
<th>Year</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5
Review of Systems

Please circle all that apply.

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

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: __________________________________________ Date ____________________________

If not patient, state relationship __________________________ Date ____________________________