H. Rand Tolboe, DPM
Christian R. Tolboe, DPM, AACFAS, CWS
David Paxton, DPM, MHA

TOLBOE
Foot & Ankle

1401 Spanos Ct., Ste. 104, Modesto, CA 95355 Phone: (209) 525-3150 Fax (888) 491-3281

VERY IMPORTANT:

TO AVOID BEING CHARGED FOR CANCELLED OR MISSED APPOINTMENTS

In order to provide all of our patients the best care possible in a timely fashion, it is essential that we keep missed appointments to a minimum. When appointments are cancelled or missed without addequate notice, we cannot offer that time to other patients who are eager to be seen. Unfortunately, the increasing frequency of cancelled or missed appointments without enough notice has required that we implement the following policy:

POLICY FOR CANCELLED/MISSED APPOINTMENTS

If you are unable to keep a scheduled appointment, please notify our office with 24 hours' notice. If you are unable to provide 24 hours' notice this will be considered a no show and a fee of $25 will be assessed to you. This fee is not billable to your insurance and is the patient's responsibility.

As a courtesy, every effort will be made to call the patient the day before to remind them of their appointment; however, this is not a guarantee. Please feel free to call at any point to confirm an appointment or to check on an upcoming date. The office phone number is (209) 525-3150.

Name of Patient: ____________________________________DOB: ______________

I have read and I understand the terms listed above in this policy.

Signature of Patient: ________________________________ Date: ______________
Signature of Parent or Guardian: ______________________ Date: ______________

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PATIENT INFORMATION:

Last Name: ____________________ First Name: ___________________ MI: ____ ☐ Male ☐ Female

DOB: ________________ Age: ______ SSN: _____________________

Billing Address: ___________________________ City: ________________ State: _____ Zip: __________

Street Address: ____________________________ City: ________________ State: _____ Zip: __________

Home Phone: ___________________ Cell Phone: _________________ Work Phone: _________________

Email Address: _____________________________________ Preferred Phone: ______________________

Language Spoken: _________________ Ethnicity: ___________________ Marital Status: M S D W

Employer: __________________ Employer Address: ____

INSURANCE INFORMATION:

Primary: ____________________ ID: ________________________ Group #: ______________________

Subscriber Name: ________________________ DOB: ______________ SSN: _______________________

Employer Name: _________________________ Phone: _______________

Secondary: __________________ ID: ________________________ Group #: ______________________

Subscriber Name: ________________________ DOB: ______________ SSN: _______________________

Employer Name: _________________________ Phone: _______________

MINOR PATIENT:

Parent or Legal Guardian Name: __________________________________ DOB: ____________________

Mailing Address: ____

Responsible Party Name: _______________________________________ Phone Number: _____________

EMERGENCY CONTACT:

Name: _______________________________ DOB: __________ Relationship: _____________________

Home Phone: ___________________ Cell Phone: _________________ Work Phone: _________________

PLEASE READ AND SIGN: I authorize Dr. H. Rand Tolboe, Dr. Christian R. Tolboe, or Dr. David E. Paxton to furnish my insurance company or Medicare all necessary information regarding my present injury or illness. I also authorize payment of medical benefits directly to Tolboe Foot & Ankle, Inc. for any medical supplies or services rendered. I understand that I am financially responsible for all services. It is understood that any overpayment will be reimbursed to me promptly. I authorize Dr. H. Rand Tolboe, Dr. Christian R. Tolboe, or Dr. David E. Paxton to perform an examination, create a plan of care regarding my present foot and/or ankle injury or illness, and treat said injury or illness. A copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient: ____ Date: ___________
Signature of Responsible Party/Legal Guardian: ______________________________ Date: ___________

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PATIENT NAME: ______________________________**DOB:**____________ **DATE:** _____________________

CHIEF COMPLAINT/PROBLEM AREA: ____

MEDICAL INFORMATION: Please circle and fill in blanks as necessary

Current Weight: ________lbs. Height: _________

Have you had any surgeries in your life? ☐ Yes ☐ No

Type of Surgery: _______________________________ Year: _____________ Dr: _______________________

Do You Smoke? ☐ Yes ☐ No ☐ Former

If YES, how often: _____________________ If FORMER, how recent: ____________________________

Do you drink Alcohol? ☐ Yes ☐ No If YES, how often: _______________________________________

Do you use recreational drugs? ☐ Yes ☐ No If YES, what kind and how often: ________________________

Allergies to Medication (NAME AND REACTION): ____

Are you allergic to Topical Iodine? ☐ Yes ☐ No Are you allergic to Latex? ☐ Yes ☐ No

Current Medications - NAME, DOSAGE, AND FREQUENCY:

____

____

____

____

What local Pharmacy Do You Use? Name: __________________________ Street: _____________________________

Primary Care Physician: ___________________ Phone: _____________ Date of Last Visit: ____________________

MEDICAL HISTORY:

Have you ever been told by a physician that you have (Please Check):

☐ Diabetes ☐ Kidney Problems ☐ Rheumatic Fever ☐ Arthritis
☐ Gout ☐ Blood Clots/DVT ☐ Epilepsy ☐ Lung Problems
☐ Tuberculosis ☐ Stroke ☐ Heart Failure ☐ Anemia
☐ Depression/Anxiety ☐ Liver Problems ☐ Circulatory Problems ☐ Asthma
☐ Cancer ☐ Heart Attack ☐ High Blood Pressure ☐ Ulcers
☐ Bleeding Disorder ☐ Irregular Heartbeat ☐ Varicose Veins ☐ Heart Disease
☐ C. Diff Positive ☐ MRSA Positive ☐ Hypothyroidism ☐ High Cholesterol
☐ Fibromyalgia ☐ Other__________ ☐ **NONE**

Are you subject to (Please Check):

☐ Chest Pain ☐ Back Pain ☐ Foot/Leg Cramps ☐ Difficulty Breathing/Shortness of Breath
☐ Burning Pain ☐ Foot Pain at Rest ☐ Swelling Of Legs ☐ **NONE**

Do you have an immediate family history of (Please Check):

☐ Diabetes ☐ High Blood Pressure ☐ Arthritis ☐ Cancer ☐ Heart Disease ☐ **NONE**

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Patient Consent to Release Information

Name of Patient: ______________________________________ DOB: ____________________

(Please print)

I give permission to Tolboe Foot & Ankle, Inc. to contact me by using any of the following indicated methods for giving test results, discussing medical information, and/or confirming appointments.

Please mark all that apply:

- ☐ Mail
- ☐ Phone call — May we leave a message? ☐ Yes ☐ No
- ☐ Cellular Phone — May we leave a message? ☐ Yes ☐ No
- ☐ E-mail

Please list all authorized individuals to whom we may release health information.

Name(s) and Relationship:

____

____

____

____

Signature of Patient: ____ Date: _______________

Signature of Parent or Guardian: ______________________________ Date: ________________