Great Plains Foot & Ankle Specialists

RECONSTRUCTIVE FOOT AND ANKLE SURGERY
WWW.GPFOOTANDANKLE.COM

RICHARD RASKA, DPM
JOSH WRAY, DPM
DUSTY CHRISTENSEN, DPM, MHA

WELCOME:
The doctors and staff at Great Plains Foot and Ankle Specialists welcome you to our office. Your health and wellbeing are our primary concern. We hope the information provided answers your questions about our services and procedures.

OFFICE HOURS:
Our office is open to serve you, answer your questions, or schedule an appointment during the following hours:
9:00 AM to 5:00 PM – Monday through Friday
Our office is closed on the weekends and major holidays.

REGISTRATION:
On your first visit to our office, you will be asked for basic information to establish your medical record and business account. Please bring your CURRENT INSURANCE CARD AND INFORMATION. Notify our office of any changes in name, address, phone number, or insurance as soon as any change occurs. We will also need a LIST OF MEDICATIONS you are currently taking.

PAYMENT:
We do require that you pay your co-pay on the day of your visit. Any supply, including orthotics, most likely will not be covered by insurance; therefore, you will be responsible for any amount on your account that insurance does not cover. If needed, payment arrangements can be made. We accept Visa, Discover, and MasterCard.

WORKERS COMPENSATION:
As a courtesy to our patients, we will file worker's compensation claims. However, if the claim is denied, unsettled or unpaid within 60 days, we will request that you file a personal health insurance claim or pay the charges in full.

THANK YOU:
We appreciate your selection of our office to meet your health service needs. If you have any questions or concerns, please feel free to contact our office at 308-532-3600 or visit our website at NEBFOOTANDANKLE.COM.

Great Plains Foot & Ankle Specialists

RECONSTRUCTIVE FOOT AND ANKLE SURGERY
WWW.GPFOOTANDANKLE.COM

RICHARD RASKA, DPM
JOSH WRAY, DPM
DUSTY CHRISTENSEN, DPM, MHA

PATIENT HISTORY

PRINT PATIENTS NAME:_____

DATE OF BIRTH:_____**HEIGHT:**_____**WEIGHT:**_____**SHOE SIZE:**_____

PATIENT'S PHARMACY:_____

TOWN PHARMACY IS LOCATED:_____

PATIENTS SOCIAL HISTORY:

- CURRENT DAILY SMOKER? YES / NO
- CURRENT OCCASIONAL SMOKER? YES / NO
- FORMER SMOKER? YES / NO
- USE CHEWING TOBACCO? YES / NO
- DRINK ALCOHOL? YES / NO
- USE RECREATIONAL DRUGS? YES / NO

IS THE PATIENT DIABETIC?

YES / NO
TYPE I / TYPE II
INSULIN? YES / NO
NON INSULIN? YES / NO

ARE YOU PREGNANT? YES / NO

PATIENTS FAMILY HISTORY:

- DIABETES? YES / NO
- STROKE? YES / NO
- CANCER? YES / NO
- HEART PROBLEMS? YES / NO

PLEASE LIST PAST SURGERIES:

_____
_____
_____
_____

PLEASE GIVE US A COPY OF A CURRENT MED LIST OR LIST ANY MEDICATIONS YOU MAY BE TAKING:_____

_____

_____

PLEASE LIST ANY MEDICATION ALLERGIES THE PATIENT MAY HAVE:

_____

_____

PLEASE CIRCLE THE FOLLOWING HEALTH ISSUES THAT YOU HAVE BEEN DIAGNOSED WITH:

ANEMIA	COPD	HEPATITIS B	HIGH CHOLESTEROL	RHEUMATIC FEVER	TB
ARTHRITIS	EMPHYSEMA	HEPATITIS C	JAUNDICE	SEASONAL ALLERGIES	STROKE
ASTHMA	FAINTING SPELLS	HEART PROBLEMS	KIDNEY DISORDERS	STOMACH ULCERS	TIA
CANCER	HEPATITIS A	HIGH BLOOD PRESSURE	LIVER DISEASE	THYROID DISORDER	

PLEASE LIST ANY OTHER HEALTH ISSUES THAT ARE NOT LISTED ABOVE:

_____

_____

PATIENTS SIGNATURE:_____**DATE:**_____

815 S. MAPLE ST. NORTH PLATTE, NE 69101
P: 308.532.3600 F: 308.532.6288 E: INFO@GPFOOTANDANKLE.COM

Great Plains Foot & Ankle Specialists

RECONSTRUCTIVE FOOT AND ANKLE SURGERY
WWW.GPFOOTANDANKLE.COM

RICHARD RASKA, DPM
JOSH WRAY, DPM
DUSTY CHRISTENSEN, DPM, MHA

PLEASE FILL IN ALL THE INFORAMTION IN ORDER FOR US TO FILE YOUR INSURANCE

PATIENT REGISTRATION FORM

FIRST NAME_____MIDDLE INITIAL_____LAST NAME_____

SEX: M/F SOCIAL SECURTIY #_____ BIRTHDATE_____

PATIENT'S ADDRESS _____CITY _____STATE_____ZIP_____

PATIENT'S PHONE (_____) _____ WORK (_____) _____CELL (_____) _____

PATIENT'S PRIMARY PHYSICAN_____MONTH/DAY/YEAR LAST SEEN_____/_____/_____

PATIENT'S PHARMACY_____TOWN_____

OCCUPATION_____EMPLOYER_____

RESPONSIBLE PARTY BRINGING IN PATIENT–NAME_____BIRTHDATE_____/_____/_____

RESPONSIBLE BILLING PARTY: SELF / SPOUSE / PARENT

REFERRAL: PHYSICAIN /FAMILY OR FRIEND /INTERNET /RADIO /TELEVISION /NEWSPAPER /OTHER_____

INFORMATION OF THE PRIMARY HOLDER OF INSURANCE POLICY

FIRST NAME_____LAST NAME_____PHONE# (_____) _____

ADDRESS_____CITY_____STATE_____ZIP_____

BIRTHDAY_____/_____/_____ SOCIAL SECURITY#_____/_____/_____

EMPLOYER_____ADDRESS_____PHONE# (____) _____

IS THIS WORKMEN'S COMP? YES / NO

WHY ARE WE SEEING YOU TODAY? _____

_____

WE WILL FILE YOUR PRIMARY INSURANCE. PLEASE NOTE THAT IF YOUR DEDUCTIBLE HAS NOT BEEN MET, YOU ARE RESPONSIBLE TO PAY THAT PORTION AND / OR THE PERCENTAGE THAT YOUR INSURANCE DOES NOT PAY AT THE TIME SERVICE IS RENDERED.

****WHEN REQUESTING A COPY OF MEDICAL RECORDS WE ASK FOR A WEEKS NOTICE. WE ARE UNABLE TO RELEASE X-RAYS. WE DO REQUIRE A $25.00 SURCHARGE FOR COPYING OF MEDICAL RECORDS AND FILLING OUT ANY FORMS****

I AUTHORIZE THE RELEASE OF MEDICAL INFORAMTION NECESSARY TO PROCESS ANY CLAIM(S). I AUTHORIZE PAYEMNT OF BENEFITS TO DR RICHARD J. RASKA, DR JOSHUA H. WRAY OR DUSTIN L. CHRISTENSEN AT THE TIME SERVICES ARE RENDERED. THERE WILL BE A $5.00 MONTHLY FEE ADDED TO ALL PATIENTS BALANCES NOT PAID IN FULL WITHIN 30 DAYS.

SIGNATURE: _____ **DATE:** _____

815 S. MAPLE ST. NORTH PLATTE, NE 69101
P: 308.532.3600 F: 308.532.6288 E: INFO@GPFOOTANDANKLE.COM