

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 GPFOOTANDANKLE.COM.

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 | N/A |
| 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 CHECK 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: _____



RICHARD RASKA, DPM
JOSH WRAY, DPM

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 DO REQUIRE A \$25.00 SURCHARGE FOR COPYING OF MEDICAL RECORDS AND FILLING OUT ANY FORMS. X-RAYS ARE MADE AVAILBLE FOR \$5.00 CHARGE.****

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: _____