



# Foot & Ankle Specialists

of West Michigan

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## PATIENT INFORMATION

(PLEASE PRINT WITH INK PEN)

FULL LEGAL NAME		DATE	
ADDRESS	CITY	ZIP	
HOME PHONE	BUSINESS PHONE	SOCIAL SEC. NO.	
DATE OF BIRTH	AGE	SEX M F	MARITAL STATUS S D M W SEP
REFERRED BY	PERSONAL PHYSICIAN		
PATIENT'S EMPLOYER	POSITION		
BUSINESS ADDRESS			
SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	SPOUSE'S EMPLOYER	SPOUSE'S WORK PHONE

## PERSON RESPONSIBLE FOR BILL

(IF OTHER THAN ABOVE)

FULL LEGAL NAME	RELATIONSHIP
ADDRESS (IF OTHER THAN ABOVE)	HOME PHONE
EMPLOYER	POSITION
BUSINESS ADDRESS	BUSINESS PHONE

## INSURANCE, MEDICARE, WORKER'S COMPENSATION or WELFARE INFORMATION

COMPANY OR PROGRAM	INSURED SS#	GROUP NUMBER	POLICY NUMBER	POLICY HOLDER'S DATE OF BIRTH
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1. \_\_\_\_\_

2. \_\_\_\_\_

IS THIS VISIT AUTO OR WORKER'S COMPENSATION RELATED?  YES  NO IF YES, DATE OF INJURY: \_\_\_\_\_

DO YOU HAVE A HIGH DEDUCTIBLE INSURANCE PLAN, HSA OR HRA INSURANCE? \_\_\_\_\_

## NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

(IF NOT ALREADY LISTED)

NAME	RELATIONSHIP
ADDRESS	HOME PHONE
EMPLOYER	POSITION
	BUSINESS PHONE

## FINANCIAL POLICY

I hereby authorize the physicians of Foot & Ankle Specialists of West Michigan, to release medical information including my diagnosis, medical history, and other material contained within those records to referring physicians, hospitals, laboratories, therapists, and employers (if applicable), as deemed necessary. I also authorize the release of information necessary for processing my insurance, liability, Workers Compensation, or litigation claims. I authorize payment of benefits, where applicable, directly to these physicians otherwise payable to me for these services.

I have had an opportunity to review the payment policy of Foot & Ankle Specialists of West Michigan, I agree to the terms of this policy, and accept the responsibility that payment is ultimately my obligation, should I not stay within the parameters of my insurance plan. Payment is expected when the service is given for any unauthorized services, deductibles, co-insurances, co-pays, non-covered services, or self-pay accounts (unless prior arrangements have been made with the site manager).

\_\_\_\_\_  
Patient signature, or guardian if patient is a minor

\_\_\_\_\_  
Date



## GENERAL INFORMATION

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Describe your foot problem: \_\_\_\_\_

How long has it been bothering you? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Years

What is your: Shoe Size \_\_\_\_\_ Shoe Width \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

## MEDICAL INFORMATION

*THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH*

Do you have Diabetes?  YES  NO Number of years \_\_\_\_\_ If yes, do you take insulin?  YES  NO

List serious illnesses: \_\_\_\_\_

List previous surgeries: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date you last saw this Doctor: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_

Are you allergic to any medication or substances?  YES  NO If yes, please list: \_\_\_\_\_

List the medications & dosages you take regularly: \_\_\_\_\_

Are you or could you be pregnant:  YES  NO

### Review of Systems:

Please indicate any symptoms you have experienced in the last 12 months:

#### CARDIAC:

- Shortness of Breath
- Chest Pains
- Irregular Heart Beat

#### GASTROINTESTINAL:

- Difficulty Swallowing
- Tooth Abscess / Infection
- Indigestion / Heartburn
- Nausea / Vomiting
- Diarrhea
- Blood in Stool
- Stomach Pains

#### GENERAL:

- Common Cold
- Weight Loss
- Weight Gain
- Fever / Chills
- Night Sweats
- Multiple Joint Pains

#### NEUROLOGIC:

- Blurred Vision
- Migraines
- Headaches
- Numbness / Tingling
- Dizziness
- Depression

#### RESPIRATORY:

- Wheezing
- Shortness of Breath
- Chronic Cough

#### SKIN:

- Open Sores / Rashes
- Changing Moles
- Non-Healing Sores

#### VASCULAR:

- Bleeding Disorder
- Blood Clots
- Swollen Legs
- Easy Bruising
- Difficulty Stopping Bleeding after Surgery

### Past Medical History:

Have you ever been treated or been informed by a physician that you have had any problems with the following?

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> HIV / AIDS            | <input type="checkbox"/> Polio           |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Drug Abuse       | <input type="checkbox"/> Intestinal Problems   | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Gout             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Sleep Apnea     |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Healing Problems | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stomach Ulcers  |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart            | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Circulatory Disorder    | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Tuberculosis    |

Do you have any surgically placed prosthesis? (heart valve, hip joint, etc.)  YES  NO

Do you smoke?  YES  NO Number of packs per day: \_\_\_\_\_ How long? \_\_\_\_\_

Have you smoked previously?  YES  NO Number of years: \_\_\_\_\_

Do you drink alcohol or beer?  YES  NO \_\_\_\_\_ Light usage (1-2 weekly) \_\_\_\_\_ Moderate usage (1-2 daily) \_\_\_\_\_ Heavy usage (2+ daily)

Employment: \_\_\_\_\_ Sit at Job \_\_\_\_\_ Stand at Job \_\_\_\_\_ Stand and Walk at Job \_\_\_\_\_ Retired

## FAMILY HISTORY

Mother:  Living  Deceased Cause of death \_\_\_\_\_

Father:  Living  Deceased Cause of death \_\_\_\_\_

Brother:  Living  Deceased Cause of death \_\_\_\_\_

Sister:  Living  Deceased Cause of death \_\_\_\_\_

Is there a family (blood relative) history of:

- |  |   |                                   |  |  |
|--|---|-----------------------------------|--|--|
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Bunions                              | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hammertoes    | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Circulation Problems in Legs or Feet | <input type="checkbox"/> Flatfeet | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke                |

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_