Advanced Foot and Ankle Associates

1621 44th St SW, Suite 500 · Wyoming, MI 49509
616.538.4442

Patient Information (*please print*)

Name: _____
Legal First M. I. Last

Birthdate: _____ Age: _____ Gender: Male / Female (circle one) Social Security #: _____-_____-_____

Address_____ City_____ State_____ Zip_____

Preferred Phone Number (____)_____ Other (____)_____

Email Address: _____

Ethnicity: (Circle One) Hispanic/Latino ***or*** Non-Hispanic/Non-Latino Primary Language: _____

Race: (Circle One) White/Caucasian American Indian/Alaska Native Asian
Black/African American Native Hawaiian/Other Pacific Islander

Martial Status: _____

Employer Information

Employment Status: Unemployed / Retired / Part Time / Full Time (circle one)

Employer _____ Department _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Legal Representative: _____ Social Security #: _____

How did you hear about us? (Circle) Physician Friend Yellow Pages Internet Sign Other: _____

PCP Information

Primary Care Physician's Name _____ Phone (____) _____

Emergency Contact

Person to contact in case of emergency_____ Relationship _____

Home Phone (____)_____ Work Phone (____) _____ Cell Phone (____) _____

Insurance Information

Primary Insurance Carrier _____

Subscriber: _____ Group: _____

Fill out if subscriber is not patient: Relationship to Patient: _____

Name: _____
First M.I. Last

Birthdate: _____ Gender: Male / Female (circle one) Social Security #: _____-_____-_____

Employer _____ Department _____ Phone (____) _____

Secondary Insurance Carrier _____

Subscriber: _____ Group: _____

I agree that if a health care worker of this practice is accidently exposed to blood or other bodily fluids from myself, that I will be tested for HIV and Hepatitis-B. This is in accordance to the State of Michigan, Dept of Health, Act 488 of 1988.

Signature_____ Date_____

I authorize payment of medical benefits by the insured directly to Advanced Foot and Ankle Associates. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself and for any yearly deductible or co-payment amounts. I authorize Advanced Foot and Ankle Associates to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.
Signature_____ Date_____

CURRENT MEDICATIONS (Please attach list if needed) _____

_____

_____Anticoagulant Use?_____

MEDICATION ALLERGIES- I HAVE NO KNOWN DRUG ALLERGIES (Please Initial)_____

__Adhesives/Tape	__Codeine	__Latex	__Novocaine	__Sulfa	Other Medicine Allergies
__Antihistamines	__Demerol	__Nylon/Plastics	__Sutures		_____
__Aspirin	__Iodine	__Metal (i.e. Nickel)	__Penicillin	__Vinyl	_____

What is your foot complaint?_____

When did this problem start?_____

Have you had foot treatment before? Yes____ No____ By Whom?_____

What was the treatment?_____

Do you have an injury related to a work accident _____ vehicle accident_____(Check that apply)

If yes, Date of Injury _____Case #_____Billing Contact_____Phone_____

Pharmacy Information: Pharmacy _____ Location _____

Constitutional			☐No	☐Yes	Hiatal hernia	☐No	☐Yes	Painful Leg swelling
☐No	☐Yes	Fever/chills	☐No	☐Yes	Ulcer	**Musculoskeletal**		
☐No	☐Yes	History of falls/near falls	**Immunologic**			☐No	☐Yes	Back/neck pain
☐No	☐Yes	Increased thirst	☐No	☐Yes	Gout	☐No	☐Yes	Hip pain
☐No	☐Yes	Unintentional weight loss or gain	☐No	☐Yes	Hepatitis carrier	☐No	☐Yes	Joint pain
Cardiovascular			☐No	☐Yes	HIV	☐No	☐Yes	Weak legs/ankles
☐No	☐Yes	Calf cramping with walking	☐No	☐Yes	Rheumatoid arthritis	**Neurologic**		
☐No	☐Yes	High Blood Pressure	**Dermatologic**			☐No	☐Yes	Burning
☐No	☐Yes	History of heart attack	☐No	☐Yes	Groups of blisters	☐No	☐Yes	Increased sensitivity
☐No	☐Yes	Heart Murmur	☐No	☐Yes	Itchy skin	☐No	☐Yes	Paralysis
Endocrine			☐No	☐Yes	Lower leg ulcers	☐No	☐Yes	Numbness
☐No	☐Yes	"Borderline" / pre diabetes	☐No	☐Yes	Non healing wounds	☐No	☐Yes	Tingling
☐No	☐Yes	Delayed wound healing	☐No	☐Yes	Psoriasis	**Psychiatric**		
☐No	☐Yes	Diabetes	☐No	☐Yes	Rash	☐No	☐Yes	Addictive tendencies
☐No	☐Yes	Low blood sugar	**Lymphatic**			☐No	☐Yes	Anxiety
Gastrointestinal			☐No	☐Yes	Lymphedema	☐No	☐Yes	Depression
☐No	☐Yes	Heartburn/reflux disease	☐No	☐Yes	Ankle edema	☐No	☐Yes	Memory loss

Fall Risk:

☐No	☐Yes	Do you feel unsteady on your feet?
☐No	☐Yes	Do you have a fear of falling?
☐No	☐Yes	Do you stumble or shuffle your feet when walking?
☐No	☐Yes	Do you touch or hold onto furniture while walking?

Past Medical History (write "mother" or "father" for those that apply)

You	Mother/Father		You	Mother/Father		Other Medical Problems
____	_____.	Anxiety/Depression	____	_____.	Hepatitis	_____
____	_____.	Atherosclerosis	____	_____.	High Blood Pressure	_____
____	_____.	Bleeding Tendencies	____	_____.	Kidney Disease	_____
____	_____.	Cancer	____	_____.	Leg Cramps	_____
____	_____.	Diabetes	____	_____.	Liver Trouble	_____
How long? _____			____	_____.	Rheumatism/Arthritis	_____
Last Primary Care Visit? _____.			____	_____.	Stomach Ulcers	_____
Shoe Size? _____			____	_____.	Stroke	_____
____	_____.	Gout	____	_____.	Painful Varicose Veins	_____
____	_____.	Heart Murmur	____	_____.	Venereal Disease	
____	_____.	Heart Trouble				

Please list all previous surgeries _____

Are you on a diet? YES NO Describe briefly_____

Are you pregnant? YES NO Drink Alcohol? YES NO Amount _____ for _____Years / Months

Smoke Cigarettes? YES NO Packs/day _____ for _____ Years / Months

I consent to care and treatment along with photographs of my feet, for education purposes, if necessary.

_____ _____

Signature of Patient Signature of parent or guardian (if patient is a minor)