Advanced Foot and Ankle Associates

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

Patient Information (please print)

12/14

Name:	
Legal First M. I. Last Birthdate: Age: Gender: Male / Female Social Security #:	
Address City State	Zip
Preferred Phone Number () Other ()	
Email Address:	
Ethnicity: (Circle One) Hispanic/Latino <i>or</i> 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 Zij)
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	
Home Phone () Work Phone () Cell Phone ()	
Insurance Information Primary Insurance Carrier	
Subscriber: Group:	
Fill out if subscriber is not patient: Relationship to Patient:	
Name:	
Birthdate: Gender: Male / Female Social Security #:	
Circle one)	
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, th 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 government benefits directly to the party who accepts assignment. I understand that I am financially responsible for paservices or materials provided to myself and for any yearly deductible or co-payment amounts. I authorize Advanced Associates to release any information required to process my claim. This request shall remain in effect until revoked by Signature Date	ayment of all Foot and Ankle by myself in writing.
CURRENT MEDICATIONS (Please attach list if needed)	

OVER

	MEDIC	ATION ALL	EDCIEC LILAY/F	UO KNOV	AVAL DOLLG A	LLEDG			gulant Use?			
Antihistamines Demerol Mylon/Plastics Sutures Aspirin Jodine 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) Whyse, Date of Injury Case # Billing Contact Phone Pharmacy Information: Pharmacy Location Constitutional No Ves History of falls/hear falls Immunologic No Ves Painful Leg swelling No Ves History of falls/hear falls Immunologic No Ves Hippain No Ves History of falls/hear falls Immunologic No Ves Hippain No Ves History of falls/hear falls Immunologic No Ves Hippain No Ves Unintentional weight loss or gain No Ves Hepatitis carrier No Ves Joint pain No Ves Ves Ves Hippain No Ves Hippain No Ves History of heart attack No Ves Rheumatoid arthritis Neurologic No Ves History of heart attack No Ves Increased sensitivity No Ves History of heart attack No Ves Ves Increased sensitivity No Ves No No Ves Ves No Ves Ves No Ves No Ves No Ves Ves							-)	dicina Allonaica
Aspirin lodine Metal (i.e. Nickel) Penicillin Vinyl		-				_	_Novocal	ine	Suita	(otner ivie	edicine Allergies
When did this problem start? Have you had foot treatment before? YesNoBy Whom? What was the treatment? Do you have an injury related to a work accident												
When did this problem start? Have you had foot treatment before? YesNoBy Whom? What was the treatment? Do you have an injury related to a work accident	What is	your foot o	complaint?									
Have you had foot treatment before? Yes No By Whom? What was the treatment? Doe you have an injury related to a work accident												
What was the treatment?												
Do you have an injury related to a work accident												
Section Pharmacy										ply)		
Constitutional Cons											ne	
Constitutional No Yes Fever/chills												
Mo	Constit	utional				□No	□Yes	Hiata	l hernia			
No	□No	□Yes	Fever/chills			□No	□Yes	Ulcer		Muscu	loskeleta	al
No	□No	□Yes	History of falls/	near falls	5	lmmu	nologic			□No	□Yes	Back/neck pain
No	□No	□Yes	Increased thirst			□No	□Yes	Gout		□No	□Yes	Hip pain
No	□No	□Yes	Unintentional w	eight los	ss or gain	□No	□Yes	Hepa	titis carrier	□No	□Yes	Joint pain
DNO	Cardio	vascular				□No				□No	□Yes	Weak legs/ankles
DNO	□No	□Yes	Calf cramping w	ith walki	ing	□No	□Yes	Rheu	matoid arthritis	Neuro	logic	
DNO	_		-			Derma	_					J
Endocrime		□Yes	History of heart	attack		□No					□Yes	Increased sensitivity
DNO	□No	□Yes	Heart Murmur			□No		-		□No		Paralysis
DNO		_							_			
□No □Yes Diabetes □No □Yes Rash □No □Yes Addictive tendencies □No □Yes Low blood sugar Lymphatic □No □Yes Anxiety Gastrointestiral □No □Yes Lymphedema □No □Yes Description □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 sumble or shuffle your feet when walking? □No □Yes Do you touch or hold onto furniture while walking? □No □Yes Do you touch or hold onto furniture while walking? □No □Yes Do you touch or hold onto furniture while walking? □No □Yes Other Medical Problems □No □Yes Do you touch or hold onto furniture while walking? □No								Non l	nealing wounds			Tingling
Section Sec			-	healing				Psoria	asis	-		
Gastrointestinal No Yes Lymphedema No Yes Depression No No Yes Nakle edema No Yes Depression No No Yes Nakle edema No Yes Memory loss Fall Risk: No Yes Do you feel unsteady on your feet?						_		Rash				
No			Low blood suga	r								
Fall Risk: No												•
□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 Hepatitis □ Anxiety/Depression High Blood Pressure □ Bleeding Tendencies High Blood Pressure □ Bleeding Tendencies Liver Trouble □ Load Cancer Liver Trouble □ How long? Rheumatism/Arthritis □ Stomach Ulcers □ Gout □ Painful Varicose Veins □ Heart Murmur Venereal Disease □ Heart Trouble □ Hear			Heartburn/reflu	ıx diseası	e	□No	□Yes	Ankle	edema	□No	□Yes	Memory loss
□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	Fall Ris											
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Past Medical History (write "mother" or "father" for those that apply) You Mother/Father	□No	□Yes	Do you have a	fear of f	falling?							
Past Medical History (write "mother" or "father" for those that apply) You Mother/Father	□No	□Yes	Do you stumb	le or shu	ffle your fee	et whe	n walkin	g?				
You Mother/Father You Mother/Father Other Medical Problems	□No	□Yes	Do you touch	or hold o	onto furnitu	re whi	le walkin	g?				
Anxiety/Depression Hepatitis Atherosclerosis High Blood Pressure Bleeding Tendencies Kidney Disease Cancer Leg Cramps Liver Trouble How long? Rheumatism/Arthritis Stomach Ulcers Stomach Ulcers Stomach Ulcers Stowe Painful Varicose Veins Painful Varicose Veins Heart Murmur Venereal Disease Heart Trouble Heart Trouble Heart Trouble Heart Trouble 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.	Past M	edical Hist	ory (write "moth	ner" or "f	ather" for tl	hose t	hat apply	/)				
. Atherosclerosis	You	Mother/F				Ν	1other/Fa	ather			Oth	er Medical Problems
Bleeding Tendencies Kidney Disease Leg Cramps Liver Trouble Liver Trouble Liver Trouble Rheumatism/Arthritis Stomach Ulcers Stomach Ulcers Stomach Ulcers Stroke Painful Varicose Veins Painful Varicose Veins Venereal Disease Heart Murmur Venereal Disease Heart Trouble 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.				· -	sion			<u>.</u>	Hepatitis			
			Atheros	sclerosis				<u> </u>	High Blood Pres	sure		
			Bleedin	ıg Tendei	ncies	_		<u>.</u>	Kidney Disease			
Rheumatism/Arthritis			Cancer					<u>.</u>	Leg Cramps			
How long?			<u> </u>	es		_		<u>.</u>	Liver Trouble			
Last Primary Care Visit?	How lo	ng?						<u> </u>	Rheumatism/Ar	thritis		
Shoe Size?	Last Pr	imary Care	Visit?	<u>.</u>		_		<u>.</u>	Stomach Ulcers		-	
	Shoe Si	ize?							Stroke		-	
									Painful Varicose	e Veins		
			llaamt A	⁄lurmur					Venereal Diseas	se		
Please list all previous surgeries				rouble								
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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.	-											
I consent to care and treatment along with photographs of my feet, for education purposes, if necessary.	-	-										
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Signature of Patient Signature of parent or guardian (if patient is a minor)				5	. 5 1		. ,	-			•	
	Signature of Patient						Signature of parent or guardian (if patient is a minor)					

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