# Advanced Foot and Ankle Associates

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

## Patient Information (*please print*)

Name: _____
First M. I. Last Preferred/Nickname

DOB: _____ 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

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

**PCP Information**
Primary Care Physician's Name _____ Phone (____) _____

**Legal Representative information**

Legal representative name: _____

DOB: _____ Relationship: _____

**Emergency Contact**
Person to contact in case of emergency_____ Relationship _____

Primary Phone: (____) _____

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

Employer _____ Department _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

**Insurance Information**
***Primary*** Insurance Carrier _____
Contract/ Enrollee ID: _____ Group: _____

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

Name: _____
First M.I. Last

DOB: _____

Employer _____ Phone (____) _____

***Secondary*** Insurance Carrier _____

Contract / Enrollee ID: _____ 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 with 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 | __Vinyl | _____ |
| __Aspirin | __Iodine | __Metal (i.e. Nickel) | __Penicillin | | _____ |

**Pharmacy Information**: Pharmacy:_____ Location:_____

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_____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **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; Last A1C: _____ | ☐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 | ____ | _____ | 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_____

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

Smoke Cigarettes or Vape Pen? 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)**