

GRAND VALLEY FOOT AND ANKLE CENTER, P.C.

Patient name _____ Social security # _____ Date of birth _____

Address _____ City _____ State _____ Zip _____

Phone numbers: Home # _____ Work # _____ Cell # _____

Age _____ Sex _____ Marital Status _____ Employer _____

Your occupation _____ Your Primary Care Physician is _____

Primary Language _____ Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Race: American Indian or Alaska Native _____ Asian _____ Black or African American _____

Native Hawaiian or Other Pacific Islander _____ White _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name _____ SS# _____ Dob _____

Address _____ Employer _____

Phone #'s: Home _____ Work _____ Cell _____

How did you learn of Grand Valley Foot and Ankle? *please list name

Doctor _____ Friend _____ Relative _____ Yellow Pages _____ Insurance manual _____ Other _____

Insurance Information

(A photocopy of your card will be taken to obtain all necessary policy numbers and phone numbers)

Primary Insurance _____ Secondary Insurance _____

Your spouses date of birth _____

Is this a **worker's compensation** claim? Yes _____ No _____ If yes, date of injury _____

PLEASE READ CAREFULLY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CLAIMS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, UNLESS ARRANGEMENTS ARE MADE IN ADVANCE. ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. OFFICE VISITS AND PROCEDURES BILLED TO YOUR INSURANCE COMPANY AND NOT PAID WITHIN 60 DAYS BECOME THE RESPONSIBILITY OF THE PATIENT/GUARDIAN AT AN INTEREST RATE OF 19% PER ANNUM. I AUTHORIZE G.V.F.A.C. TO FURNISH INFORMATION TO MY INSURANCE CARRIERS AND OTHER DOCTORS/HEALTH INSTITUTIONS CONCERNING MY ILLNESS AND TREATMENTS. I HEREBY ASSIGN TO THE DOCTORS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. PATIENTS WILL BE CHARGED A \$25 FEE FOR MISSED APPOINTMENTS OR THOSE NOT CANCELLED WITHIN 24 HOURS. I AUTHORIZE TREATMENT FOR MY FOOT/ANKLE AND RELATED CONDITIONS.

MEDICAL RECORDS: I UNDERSTAND THAT MY MEDICAL CHART IS THE PROPERTY OF THE PRACTICE AND THAT NO ORIGINAL NOTES OR X-RAYS WILL BE RELEASED. HOWEVER, I UNDERSTAND THAT I HAVE A RIGHT TO ALL INFORMATION IN MY CHART AND THAT INFORMATION WILL BE PROVIDED TO ME WITHIN THREE BUSINESS DAYS ONCE A PROPERLY EXECUTED MEDICAL RECORDS RELEASE HAS BEEN RECEIVED BY THE PRACTICE. I UNDERSTAND THAT THERE WILL BE A CHARGE FOR A COPY OF MY RECORDS AND/OR X-RAYS.

PATIENT / GUARDIAN _____ DATE _____

PLEASE CONTINUE ON BACK >>>>>>>

PLEASE COMPLETE ALL INFORMATION

MEDICAL HISTORY

Reason for visit _____

Have you ever had problems with? (Please check only those that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Blood clot |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Kidneys |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Depression | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Peripheral vascular disease |

Other _____

List **ALL** Medications you are currently taking:

List **ALL** Allergies to Medications/Food:

List **ALL** previous Surgeries (include date / location if known) and any reaction to anesthetics:

How many cigarettes **do you** smoke per day? _____

How many alcohol drinks **do you** have per week? _____

Do you /did you use any drugs beside prescription medication? _____

Immediate Family History of: (LIST WHO)

Cancer _____

High Blood Pressure _____

Heart condition _____

Diabetes _____

Please circle any of the following conditions **you are CURRENTLY experiencing:**

Fever, chills, nausea, vomiting, weight loss, weight gain, lumps, sores, rashes, dizziness, eye sight changes, headaches, problem swallowing, ringing ears, problems breathing, pneumonia, asthma, chest pain, chest tightness, heart palpitations, heart murmur, abdominal cramping, bloody stools, diarrhea, stomach burning, discharge, pain with urination, broken bones, cramping, limb deformity, loss of consciousness, loss of use of any limb, blackouts, seizures, night sweats, excessive thirst, frequent night urination, excessive hunger, excessive bleeding, excessive bruising depression, anxiety and/or nervousness.

Is there anything else the Doctors should know about you or your medical history?
