

# GRAND VALLEY FOOT & ANKLE CENTER, P.C.

Patient name \_\_\_\_\_ Social security # \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone numbers: Home# \_\_\_\_\_ Work# \_\_\_\_\_ Other/Cell# \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital status \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Description (ie. Sit, stand, lift etc) \_\_\_\_\_

Primary care Physician/Regular Doctor \_\_\_\_\_

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

Doctor \_\_\_\_\_ Friend \_\_\_\_\_ Relative \_\_\_\_\_ Yellow Pages: US west (yellow cover) \_\_\_\_\_  
Insurance manual \_\_\_\_\_ Other \_\_\_\_\_ Mesa county directory (picture cover) \_\_\_\_\_ Telecom (black cover) \_\_\_\_\_

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## Insurance Info.

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

Primary Ins. \_\_\_\_\_

Secondary Ins. \_\_\_\_\_

Is this a **worker's compensation** claim? yes no

Claim number: \_\_\_\_\_

Date of injury \_\_\_\_\_ Circumstances of injury: \_\_\_\_\_

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## **PARENT/ GUARDIAN/ SPOUSE INFORMATION:**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBERS: HOME \_\_\_\_\_ WORK \_\_\_\_\_

## **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. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED, UNLESS ARRANGEMENTS ARE MADE IN ADVANCE. ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. OFFICE VISITS AND PROCEDURES BILLED TO MY INSURANCE COMPANY AND NOT PAID WITHIN 60 DAYS BECOME THE RESPONSIBILITY OF THE PATIENT/GUARDIAN AT AN INTEREST RATE NOT TO EXCEED 19% PER ANNUM. PATIENTS WILL BE RESPONSIBLE FOR ANY AND ALL FEES ASSOCIATED WITH THE COLLECTION OF OUTSTANDING ACCOUNTS. I AUTHORIZE G.V.F.A.C TO FURNISH INFORMATION TO INSURANCE CARRIERS 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 MAY BE RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. PATIENTS MAY BE CHARGED A FEE FOR MISSED APPOINTMENTS OR THOSE NOT CANCELED WITHIN 24 HOURS. I AUTHORIZE TREATMENT FOR MY FOOT/ANKLE AND RELATED CONDITIONS.

PATIENT/GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE COMPLETE ALL INFORMATION**

**MEDICAL HISTORY**

Reason for visit (Pain when/where)

Have you ever had treatment for this (when, where)?

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

Heart _____	High Blood Pressure _____	Seizures
Heart murmur _____	Multiple Sclerosis _____	Parkinson's _____
Lungs _____	Osteoarthritis _____	Cancer (type) _____
Cirrhosis _____	Rheumatoid Arthritis _____	Blood Clot
Hepatitis _____	Diabetes _____	Glaucoma
AIDS/HIV _____	Anxiety _____	Kidneys _____
Liver _____	Depression _____	Rheumatic fever
Asthma _____		Stroke _____
	Other _____	

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

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

List **ALL** Surgeries you have had, date of, and any reaction to anesthetics:

How many cigarettes **do you/did you** smoke per day?

How many alcohol drinks **do you/ did 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** have **RECENTLY** experienced:

(CON) Fever, Chills, Nausea, Vomiting, Weight loss, Weight gain, (integ) lumps, sores, rashes (head) Dizziness, eye sight changes, headaches, problem swallowing, ringing ears, (resp) problems breathing, pneumonia, asthma,(CV) Chest pain, Chest tightness, heart palpitations, heart murmur (GI) Abdominal cramping, bloody stools, diarrhea, stomach burning, (GU) discharge, pain with urination, (msk) broken bones, cramping, limb deformity,(Neuro) Loss of Consciousness, Loss of use of any limb, blackouts, seizures, (Endo) night sweats, excessive thirst, frequent night urination, excessive hunger, (heme) excessive bleeding, excessive bruising (psy) depression, anxiety, nervousness

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