GRAND VALLEY FOOT AND ANKLE CENTER, P.C.

Patient name _____ SS# _____-____-_____ Date of birth_____

Address_____ City _____ State ____ Zip _____

Phone numbers: Home _____ Work _____ Cell _____ Email _____

Age _____ Sex _____ Marital Status _____ Employer _____ Occupation _____

Your Primary Care Physician is _____Date last seen by PCP _____

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 / Caucasian ____

Primary Insurance: _____ **Secondary Insurance:** _____

Subscriber name (if different than patient): _____**Date of birth:** _____

Subscriber mailing address (if different than patient): _____

Subscriber phone numbers: Home ____-_____ Work ____-_____ Cell ____-_____

Responsible party (if other than patient, list name, address, d-o-b and phone number):

_____

_____

How did you learn of Grand Valley Foot and Ankle Center -

Physician _____ Friend _____Relative _____ Facebook _____ Internet _____ Yellow Pages _____ Insurance manual ____

Other – explain _____

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 CHARGGED A $25.00 FEE FOR MISSED APPOINTMENTS OR THOSE NOT CANCELLED WITHIN 24 HOURS. I AUTHORIZE TREATMENT FOR MY FOOT/ANKLE AND RELATED CONDITIONS.

Non-payment or Default: In the event of default or non-payment, any unpaid monies owed for services rendered, may be referred to a third party collection agency. The agency we use charges 35% of the unpaid principle balance owed at the time it is turned to them. Those fees become your responsibility. In addition to collection fees, principle and accrued interest, you will also be liable for all attorney's fees and court costs associated with litigation resulting from default. _____ Initial

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 COMPLETE ALL INFORMATION

MEDICAL HISTORY

Reason for visit _____

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

___ Anxiety
___ Depression
___ Heart Attack
___ Heart Disease
___ Heart murmur
___ High blood pressure
___ High cholesterol
___ COPD
___ Stroke
___ Blood clot
Location of clot _____

___ Hepatitis A/B/C
___ AIDS/HIV
___ Asthma
___ Cirrhosis
___ Rheumatic fever
___ Kidney function
___ Glaucoma
___ Osteoarthritis
___ Rheumatoid arthritis
___ Multiple Sclerosis
___ Osteoporosis

___ Seizures
___ Parkinson's
___ Alzheimer's
___ Gout
___ Diabetes
___ Peripheral vascular disease
___ Neuropathy
___ Thyroid
___ Back pain
___ Cancer
Type _____

Height _____ Weight _____ Shoe size _____

Other medical conditions: _____

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

_____

_____

List **ALL** allergies to medications / food:

_____

_____

List **ALL** previous surgeries and any reactions to anesthetics:

_____

_____

How many cigarettes **do you** smoke per day? _____
How many alcohol drinks **do you** have per day? _____
Do you use any illegal/illicit 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 our physician's should know about you or your medical history?

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