

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 ____

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 ____

Name of friend or relative _____ Newspaper / mailer _____ 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 CHARGED 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 38% 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

Describe your foot / ankle problem _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> GERD | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Asthma | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney function | <input type="checkbox"/> Diabetes I / II |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Glaucoma | HbA1c _____ |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Arthritis-type _____ | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Blood clot- location _____ | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Abnormal scar formation | <input type="checkbox"/> 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 **or** chew tobacco per day? _____

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

Did you ever use tobacco products? _____

Do you use any illegal/illicit drugs beside prescription medication? _____ **Do you** use marijuana products? _____

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, menopause symptoms. Other, please list _____

Is there anything else our physician's should know about you or your medical history?
