FOOT & ANKLE ASSOCIATES OF MICHIGAN

Clio Foot & Ankle
4091 W. Vienna Road
Clio, MI 48420
(810) 687-7350
www.cliofoot.com

1. PATIENT INFORMATION

Date:
SS/H/C/Patient ID#:
Patient Last Name:
Patient First Name: Middle Int:
Address:
City:
State: Zip Code:
E-mail:
Sex: Age: Birthdate:

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for [] yrs.

Occupation: _____
Patient Employer/School: _____
Employer/School Address: _____
_____
Employer/School Phone: _____
Spouse's Name: _____
Birthdate: _____
SS#: _____
Spouse's Employer: _____
Reason for today's visit?
_____
_____

3. PHONE NUMBERS

Home: _____
Cell: _____
Best time to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____

2. INSURANCE

Who is responsible for this account? _____
Relationship to Patient: _____
Insurance Co.: _____
Group #: _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name: _____
Birth date: _____ SS#: _____
Relationship to Patient: _____
Insurance Co.: _____
Group#: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have Insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Shelby Foot and Ankle all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Shelby Foot and Ankle for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits or benefits for related services.

X _____
Signature of Beneficiary, Guardian or Personal Representative

X _____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

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4. FAMILY HISTORY

Date of last physical examination: _____

What is the reason for your visit: _____

	Father	Present health or cause of death	Mother	Present health or cause of death	Spouse	Present health or cause of death
Alive Deceased	☐ ☐		☐ ☐		☐ ☐	

Brothers	No. Alive:	Health:	No. Deceased:	Cause of Death:
Sisters	No. Alive:	Health:	No. Deceased:	Cause of Death:
Children	No. Alive:	Ages & Health:	No. Deceased:	Ages & Cause of Death:

Check any of the illnesses which have occurred in any of your blood relatives

☐ Diabetes ☐ Cancer ☐ Bleeding Tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart Disease ☐ Stoke ☐ High Blood Pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

5. HEALTH HISTORY (All information is strictly confidential)

Check (X) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose Veins

EYE, EAR, NOSE THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double Vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes/Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN Only
- ☐ Erection difficulties
- ☐ Lump is testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period: _____

Date of last Pap Smear: _____

Have you had a mammogram? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Number of Children: _____

Check (X) conditions you have had in the past.
- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illness or operations: _____

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6. MEDICATIONS / ALLERGIES

List medications you are currently taking:

_____

Pharmacy Name: _____

Pharmacy Phone: _____

List allergies to medications or substances:

_____

7. HEALTH HABITS

Check (X) which you use and how much

☐ Caffeine _____ ☐ Street Drugs _____

☐ Tobacco _____ ☐ Other _____

Check (X) if your work exposes you to:

☐ Stress ☐ Heavy Lifting

☐ Hazardous Substances ☐ Other _____

8. SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

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Whom may we thank for referring you?

☐ Patient ☐ Doctor's Office ☐ Other

Referral Doctor: _____

Patient/Other: _____

Who is your primary care physician/family doctor? ☐ **Same as Referral Doctor**

Other: _____

Address: (if known) _____

_____

Phone: (if known) _____

Who is your Endocrinologist / Diabetic doctor? (if applicable)

Name: _____

Address: (if known) _____

_____

Phone: (if known) _____

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Patient Acknowledgment of Privacy Practices

As the laws regarding patient privacy are changing and new procedures are being put into effect, it is our responsibility to notify you as well as receive feedback from you about how your records will be handled. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

***PLEASE INITIAL that you have read and understand each statement. If you wish to make changes to a section, please notify the receptionist so that your file is noted properly in our records. Please sign and date the bottom.**

_____ I am aware that the Notice of Privacy Practices is available for me to read here in the office, and I may receive a copy upon request.

_____ I am aware the staff will identify themselves as a doctor's office when confirming appointments, returning my calls or for routine follow-up calls. I further understand any message left for me will not include test results or other identifiable medical information.

_____ I am aware my podiatrist makes it a practice to keep my primary care and/or specialty physicians notified of my progress by sending a report detailing my initial visit and subsequent visits as needed.

_____ I authorize the staff of this office to release pertinent information to any physician or provider they refer me to for future care.

_____ I authorize the following person(s)(Example: spouse, family, friend, bookkeeper) (PLEASE PRINT)

_____

_____ **to have access to my medical information, including receiving test results, taking advice regarding my condition, making my appointments and discussing my billing issues. I may change this at any time by signing a new form.**

_____ I understand that the above information is in effect immediately and shall remain in effect unless a new Patient Acknowledgment of Privacy Practices form is signed and dated with changes made by me.

Please note in order to avoid misuse of your protected medical records or information, it is our policy to release minimum amount necessary, even to those you have agreed may have access.

Signature: _____ Date: _____

Patient Name: _____

(PLEASE PRINT)