Welcome to the Michigan Foot and Ankle Center, P.C.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this two-sided form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you.
Thank you for allowing us to provide your podiatric care.

Date: ____________________

IDENTIFYING INFORMATION

Name: ____
First Middle Last

Gender: M F Age: ________ Date of Birth: ________ Marital Status: ______________

Driver's License # ____________________ Social Security # ____________________

Shoe Size: ________ Height: ________ Weight: ________

Ethnicity: o African or African American o Asian or Asian American o Caucasion or European American
o Native American or Alaskan American o Native Hawaiian or Other Pacific Islander o Other

Language Spoken: ____________________

CONTACT INFORMATION

Address: ______________________________________ County: ______________

City: ____________________ State: ______________ Zip: ______________

Home Phone: ______________ Mobile: ______________ Office: ______________ / ________ ext.

Email Address: ______________________________

Employer: ______________________________________ Phone: ______________

Emergency Contact: ______________________________ Phone: ______________

Primary Care Physician: __________________________ Phone: ______________

Address: ______________________________ Date of Last Visit: ______________

INSURANCE / PHARMACY INFORMATION

Primary Insurance ____________________ Secondary Insurance ____________________

Person responsible for account: ______________________________

Address: ______________________________________ Phone: ______________

Pharmacy Name/Cross Streets: __________________________ Phone: ______________

MEDICAL HISTORY

Reason for today's visit and when this problem(s) started: ______________________________

____

Has this problem been previously treated? ______________________________

MAJOR EVENTS, HOSPITALIZATIONS, RGERIES

List any surgeries you have had: ______________________________

____

____

ONGOING MEDICAL PROBLEMS

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- o Anemia
- o Arthritis
- o Back Problems
- o Bleeding Tendency
- o Blood Disease
- o Broken Bone (Fractures)
- o Cancer
- o Chemotherapy
- o High Cholesterol
- o Circulatory Problems
- o Diabetes
- o Epilepsy
- o Eye Condition
- o Gastrointestinal Condition
- o Gout
- o Heart Problems
- o Hemophilia
- o Hepatitis
- o High Blood Pressure
- o HIV Positive
- o Kidney Disease
- o Leg Cramps
- o Liver Disease
- o Mitral Valve Prolapse
- o Osteoporosis
- o Phlebitis (Blood Clot)
- o Polio
- o Psychiatric Condition
- o Radiation Treatment
- o Respiratory Disease (Lung)
- o Rheumatic Fever
- o Scarlet Fever
- o Shortness of Breath
- o Stroke
- o Swelling of Foot or Ankles
- o Thyroid Problems
- o Tuberculosis
- o Venereal Disease
- o **NONE OF THESE**

Are you pregnant? ______________ Nursing? ______________

FAMILY HISTORY

Have any **family** members ever had the following? Please list whom.

Diabetes ______________ Foot Problems ______________

Arthritis ______________ Heart Disease ______________

Stroke ______________ High Blood Pressure ______________

Cancer ______________ Neuromuscular ______________

MEDICATION LIST

List **all medications** you are currently taking and the dosage.

Medication	Dosage	# Times day/wk/mo
/	/	
/	/	
/	/	
/	/	
/	/	
/	/	

Medication	Dosage	# Times day/wk/mo
/	/	
/	/	
/	/	
/	/	
/	/	

o **No Medications**

ALLERGIES

Check all that apply and list the type of reaction you have to the medication.

	Reaction	Severity Mild / Moderate / Severe
o Aspirin		
o Codeine		
o Demerol		
o Iodine		
o Novocaine		
o Penicillin		
o Shrimp		
o Sulfa		
o Tape		
o Other		

o **No Known Allergies**

LIFESTYLE

Do you smoke now? (circle one) No Yes Packs/day ________ Years ________

Did you ever smoke: No Yes Packs/day ________ Years ________

Quit smoking date: ____________

Alcoholic Beverages? (circle one)	None	Rarely	Moderately	Daily	Quit
Recreational Drugs?	None	Rarely	Moderately	Daily	Quit

I authorize my insurance company to pay Michigan Foot and Ankle Center, P.C. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize michigan Foot and Ankle center, P.C. to release all information necessary to secure the payment of benefits.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY.

Signature ______________________ **Date** ______________________

Whom may we thank for referring you? ______________________