Patient Information

Grand Haven FOOT&ANKLE

NAME _____ DATE OF BIRTH _____ AGE _____

PREFERRED NAME/NICKNAME _____ GENDER: M F MARITAL STATUS: M S W D

HOME PHONE _____ OTHER PHONE _____

SOCIAL SECURITY # _____ EMPLOYER _____

HOME ADDRESS _____
STREET CITY/STATE ZIP CODE

E-MAIL ADDRESS _____

FAMILY PHYSICIAN _____ PREFERRED PHARMACY _____

DATE OF LAST VISIT TO FAMILY DOCTOR _____ SHOE SIZE _____

PLEASE CIRCLE THE FOLLOWING THAT APPLY TO PATIENT:

PATIENTS PRIMARY LANGUAGE: ENGLISH SPANISH OTHER: _____

RACE: WHITE ASIAN AMERICAN INDIAN AFRICAN AMERICAN ALASKA NATIVE HISPANIC

RESPONSIBLE PARTY/POA INFORMATION (IF OTHER THAN PATIENT)

NAME _____ DATE OF BIRTH _____ PHONE _____

HOME ADDRESS _____
STREET CITY/STATE ZIP CODE

IN CASE OF EMERGENCY, AND WE CANNOT REACH YOU, WHOM SHOULD WE NOTIFY?

NAME _____ PHONE(s) _____

INSURANCE INFORMATION

Please provide ALL insurance information you would like submitted. We are not responsible for missing insurance information resulting in denials.

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE _____	NAME OF INSURANCE _____
ID # _____	ID # _____
POLICY HOLDER _____	POLICY HOLDER _____
POLICY HOLDER SSN # _____	POLICY HOLDER SSN # _____
POLICY HOLDER DOB _____	POLICY HOLDER DOB _____

AUTHORIZATION TO DISCLOSE AND/OR REQUEST MY PROTECTED HEALTH INFORMATION

I authorize Grand Haven Foot & Ankle to furnish my protected health information to insurance carriers (including but not limited to the Center for Medicare and Medicaid) concerning my illness and treatment regarding related claims. I understand that I am responsible for any health insurance deductibles, co-insurance/co-payments, or services not covered by my insurance. I understand that it is my responsibility to contact my carrier for information regarding coverage, deductibles, and co-payments/co-insurance. I permit a copy of this authorization to be used in place of the original and request the payment of medical benefits be payable to Robbi A. Young, DPM. I also authorize the request for release of my medical records from any hospital or facility at which I have been treated. I certify that I have received a copy of the Grand Haven Foot & Ankle's Office Policies and understand them. I certify that all information contained on this document is complete and true to the best of my knowledge.

INITIALS **X:** _____

GRAND HAVEN FOOT & ANKLE NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT

I am aware that I may be given and copy of the Notice of Privacy Practices upon my own request.

INITIALS **X:** _____

OUR COMMUNICATION POLICY

It is the policy of Grand Haven Foot & Ankle to call patients and remind them of scheduled appointments 24-72 hours prior to their appointment time. The reminder calls only state patient's name, date and time of the appointment, and the name of the doctor he/she will be seeing. Grand Haven Foot & Ankle may also call and leave a message requesting a return call from the patient or responsible party if there is private information that needs to be discussed.

INITIALS **X:** _____

PATIENT ACKNOWLEDGMENT OF POLICY

I hereby authorize Grand Haven Foot & Ankle to leave messages relating to my health care and appointments on my answering machine, with the responsible party who is listed, with family members who answer the phone at my residence, or with the responsible party who is listed in my medical record.

I understand that I may refuse to allow information to be communicated with certain friends and family members. Should that be the case, Grand Haven Foot & Ankle will provide me with proper form to complete in order to make my wishes known.

INITIALS **X:** _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

INITIALS **X:** _____

By signing below and initialing above, I have read and understand the information/policies/and consents.

X: _____ **X:** _____

SIGNATURE OF PATIENT NAME OR PERSONAL REPRESENTATIVE DATE

_____ _____

PLEASE PRINT PATIENT NAME OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

_____

PATIENT'S DATE OF BIRTH

Health History

Grand Haven FOOT&ANKLE

PATIENT NAME _____ DATE OF BIRTH _____

REASON FOR TODAY'S VISIT / PRIOR TREATMENT _____

ALLERGIES: (CIRCLE ALL THAT APPLY) PENICILLIN CODEINE SULFA ASPIRIN LOCAL ANESTHETIC

OTHER (EXPLAIN): _____

MEDICATIONS _____

_____

_____

MEDICAL CONDITIONS AND SURGERIES _____

_____

_____

TOBACCO? YES NO IF YES, PPD _____ ALCOHOL? YES NO IF YES, DRINKS/DAY _____

DRUG ABUSE? YES NO SPECIAL DIET? (LIST): _____

REVIEW OF SYSTEMS Circle all that you have had, or now have, problems related to the following.			
Chills / Fever Dizzy spells Excessive thirst Hot / Cold flashes Tired / Sluggish	Blindness Blurred vision Double vision Vision impairment	Corns / callouses Nail problems Open sores Skin rash	Alzheimer's disease Anxiety Dementia Depression Memory loss
Blood clotting problem Chest pain Cold feet High blood pressure Varicose veins	Abdominal pain Heartburn Indigestion Nausea	Ear infection Hearing loss Sinus problems Sore throat	Shortness of breath Frequent cough Wheezing
Diabetes	Frequent urination Difficulty urinating Painful urination	Aches / back pain Joint pain / neck pain Limitation of motion Weakness	
Drug allergies Hay fever	Numbness / tingling Tremors		

FAMILY HISTORY	YES	NO	RELATIONSHIP
Diabetes			
Cancer			
High blood pressure			
High cholesterol			
Heart disease			
Other:			

X: _____ **X:** _____

SIGNATURE OF PATIENT NAME OR PERSONAL REPRESENTATIVE DATE

Grand Haven
FOOT&ANKLE

How did you hear about the practice?

☐ Internet/Google _____

☐ Friend/Family _____

☐ Doctor Referral (who?) _____

☐ Insurance Company _____

☐ Facebook _____

☐ Other _____

THANK YOU!