GRAND VALLEY FOOT AND ANKLE CENTER, P.C.

*Are Required Fields

*Legal Name_____ Preferred Name_____

*Date of Birth _____/_____/_____ SS#_____-_____-_____ Age: _____ Sex: □ Male □ Female □ Other

*Address _____ City _____ State _____ Zip_____

*Preferred Phone #: _____-_____-_____ Alt #: _____-_____-_____ Email _____

Marital Status: _____ Occupation: _____

***Your Primary Care Physician is** _____ ***Date Last Seen by PCP** _____/_____/_____

Primary Language _____ Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □White

Race: □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian/Other Pacific Islander

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

Subscriber Name (If Different Than Patient): _____ **Date of Birth**: _____/_____/_____

Subscriber Mailing Address: □ Same as above □ Different than Patient Listed: Please Fill In Below

Address: _____ City: _____ State: _____ Zip: _____

***Responsible Party (If other than patient OR under 18 Yrs. Old):**

Legal Last Name_____ First Name: _____
Date of Birth ____/_____/_____ *SS# If Under 18 Yrs. Old: _____-_____-_____ Phone Number _____-_____-_____
Address _____ Relationship_____

How did you learn of Grand Valley Foot and Ankle Center? □ Current Patient

□ Physician □ Social Media/Internet □ Yellow Pages □ Insurance Manual □ Newspaper/Mail □ Friend/Relative
□ Previous Patient: Date Last Seen: _____/_____ □ **Worker's compensation?** Date of Injury: _____/_____/_____

PLEASE READ CAREFULLY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGES 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 INSTITIONS 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.

***→_____ Initial** **Non-payment or Default**: In the event of default or non-payment, any unpaid money owed for services rendered, may be referred to a third party collection agency. The agency we use charges a 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 cost associated with litigation resulting from default.

MEDICAL RECORDS: I UNDERSTAND THAT MY MEDICAL CHART IS THE PROPERTY OF THE PRACTICE AND THAT NO ORIGINAL NOTES OR X-RAYS WILL BE RELEASE. 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.

***Signature:** _____ **Date** _____/_____/_____

Relationship: □ Self □ Guardian □ POA □ Other _____

PLEASE COMPLETE ALL INFORMATION

*Specify Concerns for Today's Visit: _____

□ **Left** □ **Right** □ **Both** Height _____ Weight _____ Shoe Size _____ □ Narrow □ Regular □ Wide

***MEDICAL HISTORY**: Have you/Do you have problems with any of the following? Please check only those that apply/Circle where appropriate

□ High Blood Pressure
□ High Cholesterol
□ Stroke
□ Blood Clot-Location
□ Heart Attack/Murmur/ Disease
□ A. Fib
□ Peripheral Vascular Disease
□ Cirrhosis
□ Hepatitis A/B/C
□ HIV/AIDS
□ Liver Disease
□ GERD/Acid Reflex

□ Abnormal Kidney Function
Dialysis ___Y ____N
□ Anxiety
□ Depression
□ Dementia
□ Multiple Sclerosis
□ Seizures
□ Parkinson's
□ Neuropathy
□ COPD
□ Asthma
□ Sleep Apnea

□ Oxygen / Liters _____
□ Arthritis / Type _____
□ Osteoporosis
□ Back Pain
□ Gout
□ Abnormal Scar Formation
□ Cancer
Specify _____
□ Glaucoma
□ Thyroid
□ ***Diabetes I / II: HbA1C** ____

***Who is Managing Your Diabetes?** _____
***Date Last Seen**: _____/_____/_____

Anything else our physicians should know about your medical history: Are you Currently Pregnant? □ Yes □ No

_____

List **ALL** medications you are **currently** taking: □ See Attached List

_____

_____

List **ALL** allergies to medications / food: □ See Attached List

_____

List **ALL** previous surgeries and any reactions to anesthetics: □ See Attached List

_____

_____

Have you ever used tobacco products? **Y N** □ Chew □ Smoke How many per day? _____ □ Previously: _____
How many alcoholic drinks do you have per week? _____
Do you use any illegal/illicit drugs besides prescription medication? □ Yes □ No Do you use marijuana? □ Yes □ No
How often? _____

Immediate Family History of: (List Who – Excluding Yourself)
Cancer _____ High Blood Pressure _____
Heart Condition _____ Diabetes _____

Please circle any of the following conditions **<u>you are CURRENTLY experiencing</u>**: Fever, chills, nausea, vomiting, menopause symptoms, weight loss, weight gain, lumps, sores, rashes, dizziness, eye sight changes, headaches, problem swallowing, ringing ears, problem breathing, pneumonia, asthma, chest pain, chest tightness, heart palpitations, heart murmur, abdominal cramping, bloody stools, diarrhea, stomach burning, discharge, pain with urination, 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. Other, please list;

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