Legal Name: ____ Preferred Name: ______________________

Birthdate: ____/____/______ Sex: ☐ Male ☐ Female ☐ Other: ___________ SS#: _____-_______-_____

Address: ___________________________________ City: _______________State: _____ ZIP: ___________

Phone: ________________ ☐Cell ☐ Home ☐Work Alt Phone: ______________ ☐Cell ☐ Home ☐Work

Marital Status: ____________ Employment Status: ____________ Occupation: _________________________

How you hear about us: ☐PCP ☐Family/Friend ☐Ins. Directory ☐Phone Book ☐Mail ☐SocialMedia

Primary Care Provider (PCP) Name: ______________________Date Last Seen by PCP:____/____/______

Primary INSURANCE	Secondary INSURANCE
INS Name:	INS Name:
ID #:	ID #:
Group#:	Group#:

☐Subscriber or ☐Responsible Party Information (if different than Patient)

Legal Name: _______________________________________ Preferred Name: ______________________

Birthdate: ____/____/______ Sex: ☐Male ☐Female ☐Other: _________ SS#: _____-_______-_____

Address: ___________________________________ City: _____________State: _____ ZIP: ___________

Phone: ________________ ☐Cell ☐ Home ☐Work Alt Phone: ______________ ☐Cell ☐ Home ☐Work

PLEASE READ CAREFULLY, by signing you agree and understand the items/terms listed below.

1. 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 of service, unless payment arrangements have been made in advance. All Copays, Co-Insurance and Deductibles are due at the time of service. I understand that I will be responsible for any amount not covered by Insurance.
2. I hereby Assign all Payments for services to Grand Valley Foot and Ankle Center (GVFAC) and my Provider.
3. In the event of a default or non-payment, any unpaid monies owed for services, I understand my information will be sent to a 3rd party Collections Agency. Fees may Apply.
4. I authorize GVFAC to furnish information to my Insurance Carriers and other Care Providers/Health Institutions concerning my illness and treatments.
5. I understand that my Medical Chart is the property of GVFAC and that no original notes or Xrays will be released. I may request a copy of my records, in writing, to be sent to myself or another medical provider and there may be a fee associated with copying of my records. ($10.00)

Signature: ____ Date: _____/_____/_____

Relationship: ☐Self ☐Guardian/Responsible Party ☐POA ☐Other: _____________________

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Podiatric Problems/Reason for Visit: ____

Medical History: Check the box of any of the following Health Issues that apply to YOU or a Family Member (FM):

YOU	FM		YOU	FM		YOU	FM	
		High Blood Pressure			Abnormal Kidney Function			Oxygen Use: Liters_______
		High Cholesterol			Dialysis			Arthritis, Type____________
		Stroke			Anxiety/Depression			Osteoporosis
		Blood Clot/Location__________			Dementia			Back Pain
		Heart Attack/Murmur/Disease			Multiple Sclerosis (MS)			Gout
		Atrial Fib			Seizures			Abnormal Scar Formation
		Peripheral Vascular Disease (PVD)			Parkinson's Disease			Cancer, Type _____________
		Cirrhosis/Liver Disease			Neuropathy			Glaucoma
		Hepatitis A/B/C			Asthma			Thyroid Disease
		HIV/AIDS			COPD			Pregnant, Due Date: _________
		Acid Reflux (GERD)			Sleep Apnea			Diabetes, Type ____________**

** IF Diabetic: who is managing your Diabetes? __________________________ Your last HbA1C level_______________

When did you last see your Diabetes Doctor?: ____/______/_____

Height: ______________ Weight: _________________ Shoe Size: ______________ ☐REG width ☐WIDE width

Anything else our Physicians should know about your Medical History?

____

List ALL or your Current Medications/Vitamins/Supplements below or ☐ See attached list

List ALL Allergies to Medications/Foods below or ☐ See attached list

List ALL previous Surgeries and any Reactions to Anesthesia or ☐ See attached list

Have you ever ☐Chewed or ☐Smoked Tobacco? ☐Yes ☐No How many per Day? _____ Year Quit: __________

Do you use Marijuana? ☐Yes ☐No How Often: _________

How many alcoholic drinks do you have per week? _____

Do you use any illegal/illicit drugs, not including your prescriptions? ☐Yes ☐No List: _________________________

Are you Currently experiencing any of the following? Circle if it applies to YOU:

Nausea, fever, vomiting, chills, weight loss/gain	Urinary discharge, pain with urination
Dizziness, changes in eyesight	Night sweats, excessive thirst, night urination, excessive hunger
Headaches, problems swallowing, ringing ears	Difficulty breathing, pneumonia, asthma, chest pain or tightness
Lumps, sores, rashes	Abdominal cramping, bloody stools, diarrhea, stomach burning
Broken bones, cramping, limb deformity, limb loss	Excessive bleeding, excessive bruising
Loss of consciousness, blackouts, seizures	Depression, anxiety, nervousness

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