GRAND VALLEY
Foot AND Ankle Center, P.C.

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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Foot AND Ankle Center, P.C.

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