ORTONVILLE FOOT, ANKLE & WOUND CLINIC

Name: _____
Last First

Address: _____
Street Apt # City State Zip code

Home Phone: _____ Cell Phone: _____

Email: _____

How would you like to be reminded of appointments? (please circle)

Home phone call Cell phone call Email Text Message No Reminder

Birthdate: _____ Age: _____ SSN: _____-_____-_____

Sex: _____ Height: _____ Weight:_____ Shoe Size: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone Number: _____

Martial Status (please circle): S M D W Name of Spouse: _____

Do you have health insurance: Yes No If yes, we will need a copy of your insurance card(s).

Primary Insurance Company: _____

Subscriber's Name and DOB: _____

**** If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms is the Patient's Responsibility.**

All Unpaid balances and/or denied claims are your responsibility.

Primary Care Physician's Name: _____ Phone #:_____

Date Last Seen: _____

Reason for visit: _____

When did the problem start? _____

CLIENT AGREEMENTS AND AUTHORIZATIONS

Please Review, Initial, and Sign Below.

CONSENT FOR TREATMENT I hereby consent to the treatment provided by Ortonville Foot, Ankle & Wound Clinic and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. _____

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize Ortonville Foot, Ankle & Wound Clinic to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Ortonville Foot, Ankle & Wound Clinic may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent. _____

ASSIGNEMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE/ COLLECTION FEE. I authorize payment to by made directly to Ortonville Foot, Ankle & Wound Clinic for insurance benefits payable to me. I understand that I am financially responsible to Ortonville Foot, Ankle & Wound Clinic for any covered or non-covered services as defined by my insurer. It is my responsibility to understand my insurance benefits/limitations. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorneys' fees. _____

MEDICATION HISTORY AUTHORIZATION. I authorize Ortonville Foot, Ankle & Wound Clinic to obtain my prescription information from the last two years electronically though SURESCRIPT and have that prescription information be added to my health record. _____

PRIVACY POLICY. I acknowledge I have been offered the Provider's, "Notice of Privacy Policies." My rights, including the right to see and copy my record, limit disclosure of my health information and to request an amendment to my record is explained in the policy. I understand that I may revoke, in writing, my consent for release of my health care information, except to the extent to which my doctor has already made disclosures with my prior consent. _____

Signature: _____ Date: _____

What Pharmacy do you use? _____ What location? _____

Medical History

(Please circle all that apply)

Anemia
Arthritis
Asthma
Bladder problems
Bowel problems
Cancer
Diabetes
Digestion Problems
Dizziness
Ear/Nose/ Throat Problems
Epilepsy
Fainting
Glaucoma
Gout
Hearing Loss
Hepatitis
High Blood Pressure
HIV+/AIDS
Kidney Disease
Liver Disease
Lupus
Migraine Headaches
Neuropathy
Pacemaker
Parkinson's Disease
Previous Heart Attack
Polio
Prolonged Bleeding
Psychological Problems
Sexually Transmitted Disease
Skin Problems/ Eczema/ Psoriasis
Stroke
Thyroid Disease
Ulcer
Varicose Veins
Vision
Other: _____

Please list any medications and vitamins that you are currently taking and the dosage.

_____

_____

_____

Please list any previous surgeries or hospitalizations.

_____

_____

_____

_____

Social History

Do you smoke? YES NO If yes, how much? _____ How many years? _____

Do you drink alcohol? YES NO How much? DAILY WEEKLY MONTHLY YEARLY

Do you use any other drugs? YES NO If yes, what? _____

Do you have a history of substance abuse? YES NO If yes, what substance? _____

Do you exercise? YES NO IF yes, how often/what kind? _____

Who do you live with? _____

MEDICAL INFORMATION

Family History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

□ Heart Disease: _____ □ Circulatory Disease: _____ □Neurological problems: _____
□ Cancer: _____ □ Hypertension: _____ □ Skin Disease: _____
□ Diabetes: _____ □Arthritis: _____ □ Foot Problems: _____

Is your mother currently living? Yes No Cause of death: _____

Is your father currently living? Yes No Cause of death: _____

Review of Systems

Please indicate any personal history below, circle:

•Constitutional Symptoms
- Good general health lately..... yes no
- Recent weight change..... yes no
- Fever..... yes no
- Fatigue..... yes no
- Headaches ..... yes no

•Eyes
- Eye disease or injury ..... yes no
- Wear glasses/contact lenses.....yes no
- Blurred or double vision ..... yes no

•Ears/Nose/Mouth/Throat
- Hearing loss or ringing ..... yes no
- Earaches or drainage..... yes no
- Sinus problems..... yes no
- Nose bleeds..... yes no
- Mouth sores ..... yes no
- Swollen glands in neck ..... yes no

• Cardiovascular
- Heart trouble.....yes no
- Chest pain or angina ....yes no
- Palpitation.....yes no
- Shortness of breath w/exertion.....yes no
- Swelling of feet, ankles or hands...yes no

•Respiratory
- Chronic or frequent coughs.....yes no
- Spitting up blood .....yes no
- Shortness of breath .....yes no
- Wheezing.....yes no

•Gastrointestinal
- Loss of appetite.....yes no
- Nausea or vomiting .....yes no
- Frequent diarrhea.....yes no
- Rectal bleeding or blood in stool.....yes no
- Abdominal pain .....yes no

•Genitourinary
- Frequent urination.....yes no
- Burning or painful urination .....yes no
- Blood in urine.....yes no
- Female - # of pregnancies.....
- Female - # of miscarriages .....

• Musculoskeletal
- Joint pain .....yes no
- Joint stiffness or swelling .....yes no
- Weakness or muscles or joints.....yes no
- Muscle pain or cramps.....yes no
- Back pain .....yes no
- Cold extremities .....yes no
- Difficulty in walking .....yes no

•Integumentary (skin)
- Rash or itching.....yes no
- Change in skin color.....yes no
- Change in hair or nails.....yes no
- Varicose veins.....yes no

•Neurological
- Frequent or recurring headaches .....yes no
- Light headed or dizzy.....yes no
- Convulsions or seizures.....yes no
- Numbness or tingling sensations.....yes no
- Tremors.....yes no
- Paralysis or weakness.....yes no
- Head injury.....yes no

•Psychiatric
- Memory loss or confusion.....yes no
- Nervousness.....yes no
- Depression.....yes no
- Insomnia.....yes no

• Endocrine
- Glandular or hormone problem.....yes no
- Excessive thirst or urination.....yes no
- Heat or cold intolerance.....yes no
- Skin becoming drier.....yes no
- Change in hat or glove size.....yes no

• Hematologic/Lymphatic
- Slow to heal after cuts.....yes no
- Bleeding or bruising tendency.....yes no
- Anemia.....yes no
- Phlebitis.....yes no
- Past transfusion.....yes no
- Enlarged glands.....yes no

Allergies

Do you have a history of skin reaction or other adverse reaction to:

□ Anesthetics
□ Antibiotics
□ Aspirin
□ Latex
□ Environmental Substances
□ Foods
□ Iodine
□ No Known Allergies
□ Pain Medication
□ Penicillin
□ Seasonal Allergies
□ Sulfa
□ Tape
□ Codeine

Specify above and any others: _____

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I, hereby, give my permission to Advanced Foot, Ankle, & Wound Care Center to diagnose and administer treatment of my foot condition.

Signature: _____ Date: _____ Reviewed by: _____