Welcome to the Michigan Foot and Ankle Center, P.C.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this two-sided form as completely as you can. If you have questions we will be glad to help you.

We look forward to working with you. Thank you for allowing us to provide your podiatric care.

Cell Phone: ( )_________________________

Date: _______________________________ Home Phone: ( ) _________________________

Name:____
Last First Middle

Address: ____

City: _________________________________ State: __________________ Zip: _______________

Soc. Sec. #: ____________________________Driver's Lic. #: ________________________________

Sex: ____ M ____ F Age: _______ Birthdate: _________________ Marital Status: _________

Shoe Size: _________ Height: ______________ Weight: ____________

Employer: ____ Phone #: ( ) __________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? ____

Telephone Number: ( ) ___________________________________

Person Responsible for Account: ____

Address: ____ Phone: _________________________

Primary Insurance Company: ____

Secondary Insurance Company: ____

Reason for today's visit and when this problem(s) started: ____

____

Has this problem been previously treated? ____

PRIMARY CARE PHYSICIAN'S NAME: ____

Address: ____ Date of Last Visit: _______________________

____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ☐ Anemia
- ☐ Arthritis
- ☐ Back Problems
- ☐ Bleeding Tendency
- ☐ Blood Disease
- ☐ Broken Bone (Fractures)
- ☐ Cancer
- ☐ Chemotherapy
- ☐ High Cholesterol
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eye Condition
- ☐ Gastrointestinal Condition
- ☐ Gout
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Leg Cramps
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Phlebitis (Blood Clot)
- ☐ Polio
- ☐ Psychiatric Condition
- ☐ Radiation Treatment
- ☐ Respiratory Disease (Lung)
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Swelling of Foot or Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease

☐ **NONE OF THESE**

Are you pregnant? ___________________________ Nursing? __________________

* *

Patient Email:____ **Race:**________________________

Pharmacy Name/Cross Streets:____

Pharmacy Phone:_____________________________________ **Language Spoken:**___________________

LIST ANY SURGERIES YOU HAVE HAD: ____

____

____

LIST **ALL MEDICATIONS** YOU ARE CURRENTLY TAKING AND THE **DOSAGES**: ________

____

____

ALLERGIES: (Circle all that apply and list the type of reaction you have to the medication)

Aspirin Codeine Demerol Iodine Novocaine Penicillin Shrimp

Sulfa Tape Other: ____

Do you smoke now? ____ No ____ Yes Packs/day ___________ Years ___________

Did you ever smoke? ____ No ____ Yes Packs/day ___________ Years ___________

Quit smoking date: ______________________________

Alcohol beverages? (Circle One) None Rarely Moderately Daily Quit

Recreational drugs? (Circle One) None Rarely Moderately Daily Quit

Have any **family** members ever had the following? Please list whom

Diabetes _________________________________ Foot Problems __________________________

Arthritis _________________________________ Heart Disease ___________________________

Stroke ___________________________________ High Blood Pressure ______________________

Cancer __________________________________ Neuromuscular __________________________

I authorize my insurance company to pay Michigan Foot and Ankle Center, P.C. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Michigan Foot and Ankle Center, P.C. to release all information necessary to secure the payment of benefits.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY.

Signature: ______________________________________ **Date:** __________________________________

MICHIGAN FOOT AND ANKLE CENTER, P.C.
HIPAA NOTICE PREAMBLE

As part of your health care, Michigan Foot and Ankle Center, P.C., maintains paper and/or electronic records describing your health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. Please understand that this information will serve as:

- A basis for planning your care and treatment,
- A means of communication among the many health care professionals who may or may not contribute to your care,
- A source of information for applying your diagnosis and surgical information to your billing,
- A means by which a third-party payer can verify that services billed were actually provided, and/or,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Please note that as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of the Michigan Foot and Ankle Center, P.C., Notice of Privacy Practices is posted in a noticeable and convenient location within the office. The Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Also understand that you have the right to request and keep a copy of this Notice for your own records.

This Preamble is provided to all patients of Michigan Foot and Ankle Center, P.C., and we reserve the right to change our Notice and practices, in accordance with Section 164.520 of the Code of Federal Regulation. Should Michigan Foot and Ankle Center, P.C., change its Notice, a copy of the revised Notice will be sent to the address that you have provided.

If you have any questions or concerns regarding your health information, this Preamble or the Notice of Privacy Practices of Michigan Foot and Ankle Center, P.C., please feel free to contact our HIPAA Privacy Officer at the address and/or phone number provided below.

MICHIGAN FOOT AND ANKLE CENTER, P.C.

ACKNOWLEDGEMENT/GOOD FAITH EFFORT FORM

Patient Name: ___________________________________

☐ Acknowledgement

I acknowledge that I have received the Preamble form for Michigan Foot and Ankle Center, P.C.

____ __________________
Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

☐ Good Faith Effort:

The above patient presented for treatment on this date: __________________________
and was provided with a copy of the practice's Preamble form. A good faith effort was made to obtain written acknowledgement of receipt of the Preamble form. However, an acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
____

☐ There was a medical emergency and the practice will attempt to obtain an acknowledgement at the next available opportunity.

☐ Other: ____

____

Employee Name: ____________________ Employee Signature: ________________________