Welcome To Our Office

(PLEASE PRINT) DATE _____

PATIENT INFORMATION

NAME _____ BIRTHDATE _____ AGE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOXES: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ MALE ☐ FEMALE

SOCIAL SECURITY # _____ HOME PHONE _____

PATIENT'S EMPLOYER _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____ CELL PHONE _____

GENERAL PHYSICIAN _____ REFERRED BY _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

☐ YES, I AUTHORIZE THE PHYSICIANS AND EMPLOYEES OF HOLLAND FOOT & ANKLE CENTERS TO CONTACT ME AND LEAVE INFORMATION AT THE ABOVE-DESIGNATED PHONE NUMBERS REGARDING APPOINTMENTS, LABORATORY RESULTS, X-RAYS AND OTHER DIAGNOSTIC TESTING.

☐ NO

RESPONSIBLE PARTY INFORMATION (not insurance company)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY # _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY _____ POLICY # _____

POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SOCIAL SECURITY # _____

EMPLOYER _____ HOME PHONE _____

SECONDARY INSURANCE

INSURANCE COMPANY _____ POLICY # _____

POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SOCIAL SECURITY # _____

EMPLOYER _____ HOME PHONE _____

****PLEASE COMPLETE OTHER SIDE****

FINANCIAL POLICY

Insurance is a contract between you and your insurance company. You need to be aware of your carrier's rules, regulations and payment policies, as some services are not covered benefits. It is your responsibility to call your designated primary provider to obtain prior authorization or referrals. If your primary provider does not authorize a referral, you will be responsible for the cost of the visit. All co-pays are expected at time of service. I authorize the release of medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original. I understand that I am financially responsible for all charges whether or not paid by insurance.

RELEASE OF INFORMATION

I hereby authorize Holland Foot & Ankle Centers to release any information to my insurance company or to other physician's office acquired in the course of my examination or treatment and also authorize payment directly to Holland Foot & Ankle Centers.

I hereby also authorize Holland Foot & Ankle Center to release any information to the assigned below:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____

Patient/Guardian Signature

_____

Date

Richard M. Seiler, DPM, FACFAS • Matthew J. Lappenga, DPM, FACFAS
Brent E. Van Til, DPM, FACFAS • Elizabeth A. Horton, DPM, AACFAS • Allison B. Dozeman, DPM, AACFAS

Patient Name: _____ D.O.B:_____ Height:_____ Weight:_____

By what name do you prefer to be called?_____

Describe your foot problem:_____

How long has it been bothering you?_____

List the things you have tried so far to help this problem:_____

List previous foot and/or ankle problems:_____

List previous surgical procedures done on your foot and/or ankle:_____

MEDICAL INFORMATION

Do you have Diabetes? ☐ YES ☐ NO Number of years: _____ If yes, do you take insulin? ☐ YES ☐ NO

List all previous surgeries:_____

_____

Name of your primary physician:_____

List all current medications you take regularly: _____

_____

ALLERGIES:	**YES**	**NO**		**YES**	**NO**
Iodine	☐	☐	Local anesthetics	☐	☐
Penicillin	☐	☐	Codeine	☐	☐
Sulfa drugs	☐	☐	Tape	☐	☐
Other antibiotics(please list)	☐	☐	Aspirin	☐	☐
Barbiturates or sedatives	☐	☐	Other drug allergies: _____		

Check any current or past medical problems:

☐ Alzheimers/Dementia
☐ Anemia
☐ Arthritis Where? _____
☐ Asthma
☐ Blood Clots (DVT)
☐ Cancer Type: _____
☐ Cardiac Pacemaker
☐ Damaged Heart Valves/Mitral valve prolapse
☐ Decreased Kidney Function
☐ Depression
☐ Epilepsy, Convulsions
☐ Emphesyma/COPD
☐ Gout
☐ Heart Attack(s)
☐ Heart Murmur
☐ Hepatitis A – B – C
☐ Hypertension
☐ Hyper/Hypo-active Thyroid
☐ Irregular Heart Beat
☐ Kidney Disease
☐ Liver Disease
☐ Neuropathy
☐ Peripheral Arterial Disease
☐ Polio
☐ Rheumatic Fever
☐ Stomach Ulcers/Reflux (GERD)
☐ Stroke
☐ Varicose veins

List other medical problems: _____

Do you have any surgically placed prosthesis? (heart valve, hip joint, etc.) ☐ YES ☐ NO

Are you or could you be pregnant? ☐ YES ☐ NO Breastfeeding? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO Number of packs per day: _____ How long? _____ Have you smoked previously? ☐ YES ☐ NO

Do you drink alcohol or beer? ☐ YES ☐ NO ☐ Rarely ☐ (1-2 weekly) ☐ (1-2 daily) ☐ (2+ daily)

Do you use any recreational drugs? ☐ YES ☐ NO Type _____

Employment: _____ ☐ Sit at Job ☐ Stand at Job ☐ Stand and Walk at Job ☐ Retired

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased Age: _____ Medical Conditions:_____

Father: ☐ Living ☐ Deceased Age: _____ Medical Conditions:_____

Brother: ☐ Living ☐ Deceased Age: _____ Medical Conditions:_____

Sister: ☐ Living ☐ Deceased Age: _____ Medical Conditions:_____

Signature: _____ Date: _____

Please describe symptoms you currently have or recently have had.

Name_____

Constitutional

- ❑ Fatigue_____
- ❑ Fever_____
- ❑ Chills_____

Cardiovascular

- ❑ Chest pain_____
- ❑ Chest pressure_____
- ❑ Heart palpitations_____
- ❑ Pain in legs when walking_____
- ❑ Cold feet_____
- ❑ Swelling in legs_____

Musculoskeletal

- ❑ Muscle pain_____
- ❑ Joint pain_____
- ❑ Joint swelling_____
- ❑ Recent trauma_____

Neurological

- ❑ Headaches _____
- ❑ Seizures _____
- ❑ Numbness _____
- ❑ Muscle weakness _____
- ❑ Dizziness _____
- ❑ Burning/Tingling in feet _____

Respiratory

- ❑ Cough_____
- ❑ Wheeze_____
- ❑ Shortness of breath_____

Skin

- ❑ Rash _____
- ❑ New skin lesion _____
- ❑ Wound _____
- ❑ Excessive scarring _____

Gastrointestinal

- ❑ Reflux/Heartburn_____
- ❑ Nausea_____
- ❑ Vomiting_____
- ❑ Diarrhea_____
- ❑ Abdominal pain_____

Genitourinary

- ❑ Painful urination_____
- ❑ Blood in urine_____
- ❑ Frequent urination_____

Eyes, Ears, Nose, Throat

- ❑ Vision changes_____
- ❑ Sore throat_____
- ❑ Ringing in ear_____
- ❑ Snoring_____

Heme/Lymphatic

- ❑ Bleed easily _____
- ❑ Bruise easily _____
- ❑ Swollen lymph nodes _____

Endocrine

- ❑ Frequent thirst _____
- ❑ Thyroid mass _____

Immunologic

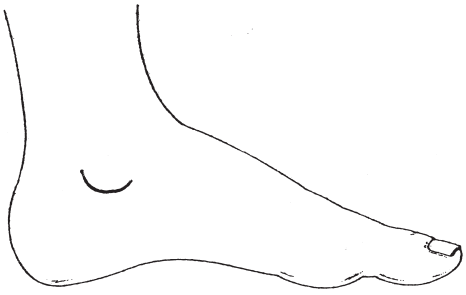
- ❑ Nasal congestion _____
- ❑ Nasal dripping _____
- ❑ Frequent infections _____

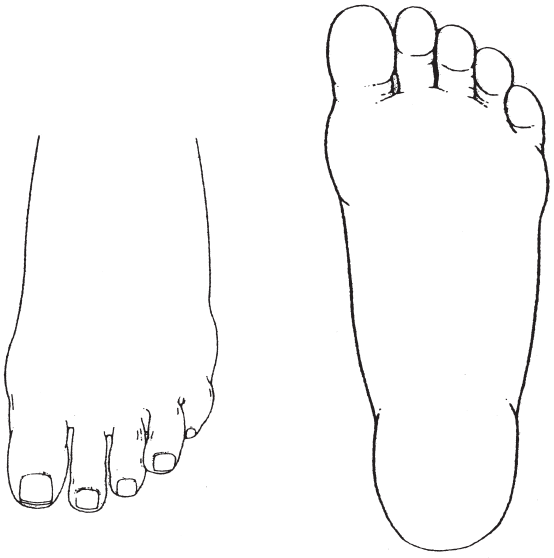
Psychiatric

- ❑ Hallucination _____
- ❑ Agitation _____
- ❑ Anxiety _____

Signature:_____ Date:_____

LEFT FOOT





RIGHT FOOT