Welcome To Our Office

(PLEASE PRINT) DATE ________________

PATIENT INFORMATION

NAME ______________________________ (FIRST / MI / LAST) BIRTHDATE ________________ AGE ________

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

LATE POLICY

If you arrive after your scheduled appointment time, it is up to the discretion of the provider if they are still able to see you. If the provider is unable to see you, we will make every effort to reschedule you for the same day. If you decide to NOT take the alternate appointment offered, you will be assessed a "no-show" for that day.

NO-SHOW POLICY

Our physicians and staff respect the time that you take to come to your appointment as well as the arrangements that may be necessary in order for you to be here. We do our best to run as close to your scheduled appointment time as possible.

We understand that unexpected things may come up that could prevent you from keeping your appointment with us. However, every time a patient does not notify us that they will be unable to keep an appointment, it prohibits another patient from being able to see one of our providers. Therefore, we want to let you know what our policy is regarding "no-shows".

We request that you let us know at least 24 hours prior to your appointment time that you will be unable to keep your scheduled appointment. If you do not do this, there will be a $25 fee per "no-show". Three "no-shows" will result in your discharge from our practice.

____
Patient/Guardian Signature

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

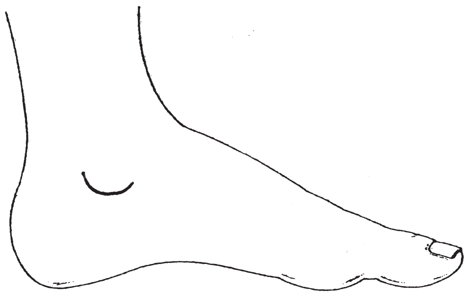
- ❑ Nasal congestion __________
- ❑ Nasal dripping __________
- ❑ Frequent infections __________

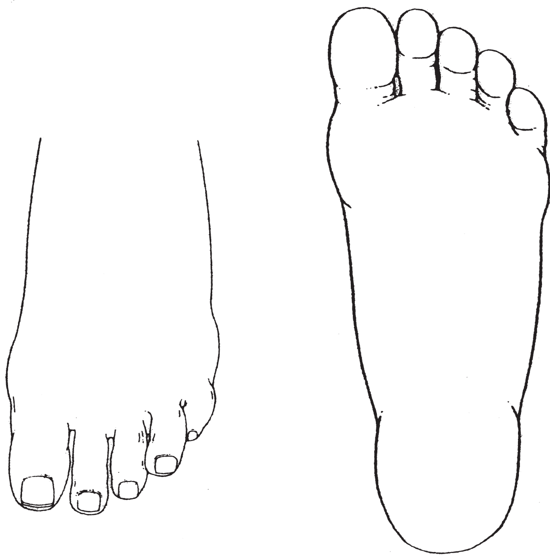
Psychiatric

- ❑ Hallucination __________
- ❑ Agitation __________
- ❑ Anxiety __________

Signature:______________________________ Date:____________

LEFT FOOT





RIGHT FOOT