

## 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 # \_\_\_\_\_ PRIMARY PHONE \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_ SECONDARY PHONE \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ ALTERNATE PHONE OR SPOUSE \_\_\_\_\_

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



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:**

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Tape	<input type="checkbox"/>	<input type="checkbox"/>
Other antibiotics(please list)	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates or sedatives	<input type="checkbox"/>	<input type="checkbox"/>	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

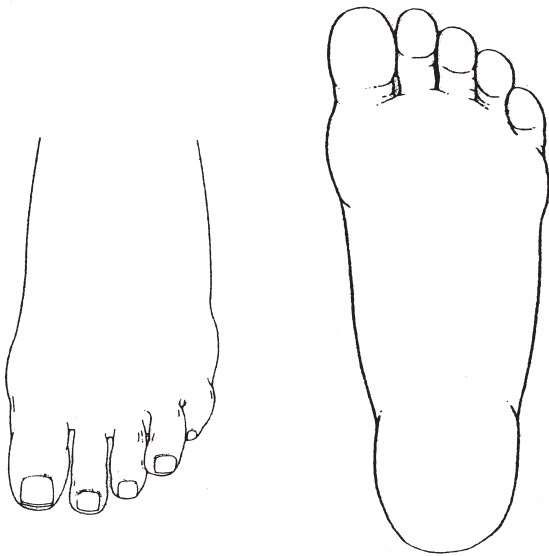
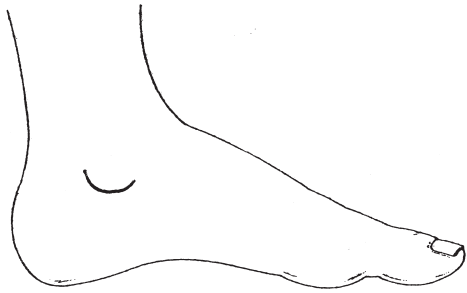
- Hallucination \_\_\_\_\_
- Agitation \_\_\_\_\_
- Anxiety \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**DRAW YOUR CONCERNS ON THE ILLUSTRATIONS**

**LEFT FOOT**



**RIGHT FOOT**

