Welcome to

Hartland Foot & Ankle

Date: _____

Patient Information

Name_____

Address_____

_____

___Female ___Single ___Divorced/Seperated

___Male ___Married ___Widowed

Birthdate_____SS#_____

Occupation_____

Employer_____

Spouse's name_____

Birthdate_____SS#_____

Phone Contact

Home phone_____Work/Cell_____

Best time to reach you_____

Emergency Contact

Name_____Relationship_____

Home phone_____Work/Cell_____

Insurance Coverage

Name of subscriber responsible for this account:

_____

Relationship to patient _____

Birthdate_____SS#_____

Is patient covered by additional insurance? YES NO

Assignment & Release

I, the undersigned, certify that I (or my dependent) have the insurance coverage presented and assign directly to Dr. Byron/Hartland Foot & Ankle all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature

_____

Date

Why are we seeing you today; how long has it been a problem?
Please be as specific as possible.

_____

_____

_____

_____

_____

_____

_____

Have you had previous foot care? YES NO

Foot conditions you have or have had in the past:

Ankle pain _____
Athlete's foot _____
Bunions/hammertoes _____
Numbness _____
Flat feet _____
Heel/arch pain _____
Ingrown nails _____
Plantar warts _____

Is there a history of diabetes?

___YES ___NO

___Personal ___Family

If YES:

___Diet control

___Oral meds

___Insulin

*Height _____
*Weight _____
*Shoe size _____
*Width _____

*Important information should orthotics or bracing become necessary.

Medical History

Please check-off any of the following conditions you currently have or may have had in the past.

( ) AIDS/HIV
( ) Allergies to anesthetics
( ) Anemia
( ) Arthritis
( ) Artificial heart valve
( ) Artificial joint replacements
( ) Asthma
( ) Back Problems
( ) Bleeding disorder
( ) Cancer
( ) Circulatory problems
( ) Diabetes
( ) Gout
( ) Heart disease
( ) Hepatitis
( ) High blood pressure
( ) Kidney problems/stones
( ) Liver disease/gall stones
( ) Nervousness/anxiety
( ) Phlebitis
( ) Radiation/chemotherapy
( ) Respiratory disease/COPD
( ) Rheumatic fever
( ) Seizure disorder
( ) Sinus conditions
( ) Stroke/head injury
( ) Tuberculosis
( ) Ulcer-stomach
( ) Ulcer-foot
( ) Varicose veins
( ) Other-please specify

_____
_____
_____

Hospitalizations & Surgeries

_____
_____
_____
_____

I learned about this office from . . .

Check one, please

( ) Dr. _____
( ) Community paper
( ) Athletic event
( ) Another patient/"word of mouth"
( ) Physical therapy or other health professional
( ) Sign/drive-by
( ) Church bulletin
( ) Yellow pages
( ) Other_____

_____

Consent for treatment

I certify that the above information is true and correct to the best of my knowledge. I give my permission to Dr. Byron to administer treatment and/or perform medical procedures, as deemed necessary and mutually agreed upon, in relationship to the diagnosis and treatment of my foot and/or ankle concerns.

_____
Signature

_____
Date

Family physician

Name & location

_____
_____

Phone #

_____

Date of last visit

_____

Medications & Allergies

Please list all prescription, over-the-counter, vitamins and supplements.
If list is extensive, we'll make a copy.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy

Name & location

_____
_____

Phone #

_____

Athletic or fitness activities you're involved in:

_____
_____
_____
_____
_____