To submit prior to appointment send via email: info@dearbornfootandankle.com or fax 313-561-7299

**Patient Last Name** **Patient Legal First Name** **Middle Initial**

**Patient Date of Birth** **Gender**
____/____/_____ ☐ Male ☐ Female

**Parent/Guardian Last Name** **Parent/Guardian Legal Fist Name** **Relationship to Patient** **PARENT Social Security #**

**Primary Language** **Race** ☐ Not Specified ☐ Middle Eastern **Ethnicity** ☐ Not Specified
☐ English ☐ American Indian ☐ Asian ☐ Alaska Native ☐ Hispanic/Latino
☐ Other _____ ☐Black/African American ☐ Native Hawaiian ☐ White ☐ Not Hispanic/Latino

**Address (No PO BOXs): Street** **City** **State** **Zip**

**Home Phone** **Cell Phone** **Email for Patient Portal**
(_____) _____ - _____ (_____) _____ - _____ _____

I understand that the above information will be used to contact me regarding appointments, treatment and billing matters. I agree to phone, text and email communications from this office, with the understanding that I can opt out of text (Msg & Data rates may apply) and emails if I so choose.

**Parent Occupation** _____ **Parent Employer** _____
Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired ☐Unemployed ☐ Student

**Emergency Contact Name** **Relationship** **Best Phone Number**
_____ ☐ Parent ☐ Other: _____ (____) ____ - ____

**Family Doctor** _____ **Town** _____ **Office Phone:** (____) ____ - ____

**How did you hear about our office?** _____

**What brings you in today (be specific):** _____ **Duration**_____

**Primary Ins. Carrier:** _____ **Secondary Ins. Carrier:** _____
**Name of policy holder:** _____ **Name of policy holder:** _____
**Policy Holder DOB:** _____ **Policy Holder DOB:** _____

## Privacy Information

Where may we contact/leave you message(s): **HOME** ☐ YES ☐ NO **CELL** ☐ YES ☐ NO

Name of person(s) who can have access to your records/PHI or pick up items for you:
Name_____ Relationship _____
Name_____ Relationship _____
Name_____ Relationship _____

## Attest

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Dearborn Foot and Ankle immediately of any changes to the above information and annually upon the office's request.

I also acknowledge that I have been provided the opportunity to take and review the office's HIPAA Policy version 6/1/2021, Authorization from Patient or Legal Representative version 6/1/2021, and Notification of Office Policies and Procedures version 6/1/2021. (available in our waiting room and/ or by request). I further acknowledge and accept all the terms and conditions outlined in all forms listed including "notifications of office policies and procedures", "HIPAA policy notice of privacy practices", and "authorization from patient or legal representative".

_____ _____ _____ _____
Print Patient's Name or Legal Representative Signature Relationship to Patient Date

# CURRENT MEDICAL HISTORY

**Patient Last Name** _____ **Patient *Legal* First Name** _____

**Patient Shoe Size** _____**Weight**_____**Height**_____ **Is Patient Diabetic** ☐Yes ☐No

**Physician that follows your diabetic care** _____ **Date last seen by PCP**_____

## Current Conditions – mark NONE if the condition below does NOT apply to you

**Symptoms:** ☐**None** ☐Chills ☐Fever ☐Nausea ☐Vomiting

**Neurological:** ☐**None** ☐Numbness/ Nerve Pain ☐Seizures ☐Strokes

**Skin:** ☐**None** ☐Cellulitis/Infection ☐Fungal Nails ☐Ingrown Nails ☐Sores ☐Rash ☐Warts

**Vascular:** ☐**None** ☐Leg/Calf Cramping ☐Cold Feet ☐Leg/Calf Cramping at rest ☐Skin red/ pale / purple

## Allergies – mark NONE if the allergies below do not apply to you

☐**None** ☐Adhesive/tape ☐Anesthetics ☐Aspirin ☐Blood thinners ☐Codeine ☐Dairy ☐Eggs ☐Erythromycin ☐Demerol ☐IV contrast dye ☐Iodine ☐Latex ☐Penicillin ☐Seafood ☐Sulfa ☐Other: _____

## Current Medications

**Medication List can be copied & attached separately if available – You do NOT have to rewrite medications**

| Medication | Dosage | How Often | Medication | Dosage | How Often |
|---|---|---|---|---|---|
| ☐**None** | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Pharmacy you prefer to use

**Pharmacy:** _____ **Crossroads:** _____ **Zip/City:** _____

## Past Medical History – mark NONE if the history below does NOT apply to you

| | | | | |
|---|---|---|---|---|
| ☐**None** | ☐CAD | ☐Gastric reflux | ☐Liver disease | ☐Seizures |
| ☐AIDS/HIV | ☐Cancer (Type) _____ | ☐Glaucoma | ☐Lung disease | ☐Skin disease |
| ☐Abnormal heart beat | ☐ Chronic back pain | ☐Gout | ☐Multiple sclerosis | ☐Stroke |
| ☐Anxiety | ☐Chemotherapy | ☐Heart attack | ☐Neuropathy | ☐Thyroid disorder |
| ☐Asthma | ☐Circulation problems | ☐Hepatitis (Type___) | ☐Osteoarthritis | ☐ Ulcers/Sores |
| ☐Bleeding disorder | ☐Dementia | ☐High Cholesterol | ☐ Parkinson's disease | ☐ Other _____ |
| ☐ Blood clot | ☐Depression | ☐High blood pressure | ☐ Rheumatoid arthritis/ autoimmune disease | _____ |
| | ☐Diabetes | ☐Kidney disease | | |

## Social History

**Smoking History** ☐ Non Smoker
☐ Current Smoker
Packs per day _____
☐Former smoker
Years of cessation _____

**Alcohol History**
☐**None**
☐Social
☐Occasional
☐Heavy

## Family History

| **Place An "X" on all applicable lines** | **Father** | **Mother** | **Both** |
|---|---|---|---|
| No significant family medical conditions | ____ | ____ | ____ |
| Unknown family history | ____ | ____ | ____ |
| Diabetes | ____ | ____ | ____ |
| Heart Attack | ____ | ____ | ____ |
| Cancer | ____ | ____ | ____ |
| Other _____ | ____ | ____ | ____ |

## Responsible Party

***The primary individual who accompanies a child (18 or under) to Dearborn Foot and Ankle Care is responsible for all fees, regardless of guardianship or custody arrangements.** All patients 18 or under must be accompanied by an adult, Responsible Party, at every appointment. This form must also be completed if the patient has a medical Power of Attorney. If the patient arrives unaccompanied to any appointment the patient will not be seen and the appointment will be rescheduled to a time when the patient can be accompanied by a responsible adult.

| **Patient Last Name** | **Patient Legal First Name** | **DOB** |
|---|---|---|
| | | |

| **Responsible Party Name** | **Relationship to Patient** | **Responsible Party DOB** | **Responsible Party SSN** |
|---|---|---|---|
| | | | |

| **Responsible Party Physical Address (Not PO BOX)** | **City** | **State** | **Zip** |
|---|---|---|---|
| | | | |

As the responsible party, if you are unable to bring the patient to their appointment you can approve up to (3) alternate adults that you consent to bring the patient to their appointments and make medical decisions for the patient in your absence. We will not be able to see the patient if they are not accompanied by a parent or an approved alternate adult listed below. **Please note that all approved parties must be prepared to pay copayment, co-insurance and/or outstanding balances when applicable.**

Approved Alternate Adult(s) that may bring the patient to appointments and make medical decisions on your behalf:

| Last Name | First Name | DOB | Relationship to Patient |
|---|---|---|---|
| | | | |
| Last Name | First Name | DOB | Relationship to Patient |
| | | | |
| Last Name | First Name | DOB | Relationship to Patient |
| | | | |

| Print Patient's Name or Legal Representative | Signature | Relationship to Patient | Date |
|---|---|---|---|