Northwood Foot and Ankle Center 388 Garden Ave. Ste. 120 Holland, MI 49424 616-393-8886

Welcome New Patient / Insurance Information

Last Name__________________________ First Name____________________ Middle initial______ Birth Date___________ Age _____

Street ________________________________ Apt. #________ City___________________ State________ Zip___________

Home Phone_________________________ Cell Phone_____________________________ Social Security #__________________________

Email _____________________________________ (This email information will not be shared but is needed for our records.)

Race (circle one): African American American Indian Asian Caucasian/White Mixed Race

Ethnicity (circle one): Hispanic/Latino Non– Hispanic/Latino **Perferred Language:** ____________________________

Marital Status (circle one): Single Married Widowed

Highest Level of Education (circle one): <High school High school Graduate Bachelor Degree Master Degree Doctorate Some College

Pharmacy you typically use:________________________________ **Location**:___________________________________

Primary Doctor:____

Employer____ Occupation__________________ Phone___________________

Name of Spouse or Parent _____________________________Social Security No.________________ Birth Date_____________

Address____________________________________City________________State_____Zip________ Phone Number__________________

Person to notify in case of an emergency:

Name____ Relationship _________________ Home Phone_________________

Street _________________________________ City________________ State_____ Zip_________ Cell Phone__________________

Insurance information:

Who is responsible for payment of this account: ____________________ Relationship:____________________________

	Name of insurance	Name of Card Holder	Card Holder's Birthday
Insurance 1	____________________________	______________________	______________________
Insurance 2	____________________________	______________________	______________________

According to HIPAA regulations, no information will be given unless authorized by the patient

I request and authorize Northwood Foot and Ankle Center to release healthcare information to:

Name:____ DOB:__________________________________

Relationship to Patient:____

This request and authorization applies to:

____ All healthcare information

____ Healthcare information dating to the following treatment, condition or dates:_______________________________________

Other:____

I have read the Missed Appointment Policy and understand that if I miss my appointment without 24 hours advance notice, a missed appointment fee will be charged to my account. ________ (Initial)

How did you hear about Northwood? (circle one)

Doctor (see below) Facebook Website Patient of ours______________________

Other: ____

If referred here by a doctor, Please list name: ____

Patient Health History:

Name____

Age_________Height__________Weight_____________ Primary Doctor:_____________________________

Other Doctor(s)/ Specialists that you see currently: Please list in the space below:____

Who Referred You Here: ____

What shoe size do you wear? ____________ Width?____________ **Medications:** (circle one) None See list

Please write down your medication on the sheet provided

If you have a current list of your medications we can take that and make a copy.

Allergy and reaction to Medications:____

____

Allergy to :

☐ **Tape If so what type** __________________ ☐ **Rubber/Latex**

Foods____**Reaction**____

Surgeries - Indicate what **type** and **year**

__________________________________ __________________________________ __________________________________

__________________________________ __________________________________ __________________________________

__________________________________ __________________________________ __________________________________

Reason for Visit:

Please describe the problem you are having: ____

____

____

ANY OTHER medical conditions that you would like the doctor to be aware of? Please mention here:

____

____

Social History:

Have you ever smoked? YES or NO If yes, How many years? _________________ Quit date?______________________

Do you smoke? YES or NO If yes, how many packs per day? ☐ 1/2 ☐ 1 ☐ 2 ☐ 3+

Do you Drink Alcohol? YES or NO If yes, how much do you drink? 1 daily 2+ daily Socially/Occasional

Do you Exercise Regularly? **YES or NO (Circle any that apply)** Walk Run Bike Sports Other___________________

Do you drink Caffeine? YES or NO ☐ Coffee ☐ Soda/Pop ☐ Tea 1-2 daily 3+ daily Occasional

Family History:

		Current Medical Condition(s)		If Deceased, Age and Cause of Death
Mother	☐ Living	__________________	☐ Deceased	__________________
Father	☐ Living	__________________	☐ Deceased	__________________
Brother(s)	☐ Living	__________________	☐ Deceased	__________________
Sister(s)	☐ Living	__________________	☐ Deceased	__________________

Have you been exposed to any infectious diseases in the past month? YES or NO Name of disease:_______________________

Diabetic: YES or NO

Insulin: YES or NO

Year Diagnosed____________

If yes, circle what type: Type 1 Type 2

Have you had any Cancer? YES or NO

What Type? ________________________

Have you ever broken a bone in your foot or ankle? YES or NO

Which bone:_______________________When:________________________

Medical History: Circle the Medical Conditions that you have now or have had in the past:

CARDIOVASCULAR

Chest Pain/Angina
Heart Attack
Congestive Heart Failure (CHF)
Coronary Artery Disease (CAD)
High Cholesterol
Swelling of the feet or ankles
High Blood Pressure
Abnormal EKG
Abnormal Heart Rhythm
Rapid Heart Rate
Artificial Heart Valve
Pacemaker
Blood Clot in Leg
Stroke
Other________________

DERMATOLIGICAL/SKIN

Rash Where? _________
Sore that's is not healing
Redness/ Itching of ankles
Fungal Infection/ Athletes foot
Warts
Skin Cancer
Other _______________

FOOT/ANKLE

Ankle Pain
Athlete's Foot
Bunions
Corns
Calluses
Flat Feet
Foot Cramps
Leg cramps
Heel Pain
Ingrown Nails
Plantar Warts
Swollen Feet
Tired Feet
Other ______________

GASTROINTESTINAL

Abdominal Pain
Change in Appetite
Constipation
Diarrhea
Gall Bladder Problems
Heart Burn
Hiatal Hernia
Nausea or Vomiting
Ulcer in Stomach
Other______________

GENITOURINARY

Abnormal Female Bleeding
Difficulty Urinating
Frequent Infections
Kidney Problems Type_________
On Dialysis – Type (Hemo) or (Peritoneal) Start Date:_________
Prostate Problems
Other_______________

HEMATOLOGICAL

Anemia
Bleeding Disorder
Circulation problems in legs
Arteries or Veins
Hemophilia
HIV Positive
Diagnosis Date:_________
Sickle Cell Anemia
Other____________

LIVER

Hepatitis
What Kind?_____________
Diagnosis Date:_________
Yellow Skin/Jaundice
Other______________

MENTAL HEALTH

Agoraphobia
Anxiety
Bipolar Disorder
Depression
Diagnosis Date:_______
Medication? YES or NO
Obsessive/Compulsive Disorder
Panic Attack
Schizophrenia
Other______________

NEUROLOGICAL

Dizziness
Fainting
Tension Headaches
Migraine Headaches
Numbness of the arms or legs
Peripheral Neuropathy
Seizures/Epilepsy
Stroke
Other______________

SKELETAL/ MUSCULAR

Arthritis
Back Problems
Gout
Limited motion in joint
Other________________

I certify that the above information is true and current to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

Signature________________________________ Date: _______________

Current Medication List

Name:________________________________ Date:_________________

Please list all medications including over the counter OR provide your current medication list.

Name of Medicine	Dose(mg)	Frequency	Reason for Taking	Who prescribed it