

# Patient Information



NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

PREFERRED NAME/NICKNAME \_\_\_\_\_ GENDER: M F MARITAL STATUS: M S W D

HOME PHONE \_\_\_\_\_ OTHER PHONE \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMPLOYER \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
STREET CITY/STATE ZIP CODE

E-MAIL ADDRESS \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PREFERRED PHARMACY \_\_\_\_\_

DATE OF LAST VISIT TO FAMILY DOCTOR \_\_\_\_\_ SHOE SIZE \_\_\_\_\_

## PLEASE CIRCLE THE FOLLOWING THAT APPLY TO PATIENT:

PATIENTS PRIMARY LANGUAGE: ENGLISH SPANISH OTHER: \_\_\_\_\_

RACE: WHITE ASIAN AMERICAN INDIAN AFRICAN AMERICAN ALASKA NATIVE HISPANIC

## RESPONSIBLE PARTY/POA INFORMATION (IF OTHER THAN PATIENT)

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
STREET CITY/STATE ZIP CODE

## IN CASE OF EMERGENCY, AND WE CANNOT REACH YOU, WHOM SHOULD WE NOTIFY?

NAME \_\_\_\_\_ PHONE(s) \_\_\_\_\_

## INSURANCE INFORMATION

Please provide ALL insurance information you would like submitted. We are not responsible for missing insurance information resulting in denials.

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE _____	NAME OF INSURANCE _____
ID # _____	ID # _____
POLICY HOLDER _____	POLICY HOLDER _____
POLICY HOLDER SSN # _____	POLICY HOLDER SSN # _____
POLICY HOLDER DOB _____	POLICY HOLDER DOB _____

**AUTHORIZATION TO DISCLOSE AND/OR REQUEST MY PROTECTED HEALTH INFORMATION**

I authorize Grand Haven Foot & Ankle to furnish my protected health information to insurance carriers (including but not limited to the Center for Medicare and Medicaid) concerning my illness and treatment regarding related claims. I understand that I am responsible for any health insurance deductibles, co-insurance/co-payments, or services not covered by my insurance. I understand that it is my responsibility to contact my carrier for information regarding coverage, deductibles, and co-payments/co-insurance. I permit a copy of this authorization to be used in place of the original and request the payment of medical benefits be payable to Robbi A. Young, DPM. I also authorize the request for release of my medical records from any hospital or facility at which I have been treated. I certify that I have received a copy of the Grand Haven Foot & Ankle’s Office Policies and understand them. I certify that all information contained on this document is complete and true to the best of my knowledge.

INITIALS **X:** \_\_\_\_\_

**GRAND HAVEN FOOT & ANKLE NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT**

I am aware that I may be given and copy of the Notice of Privacy Practices upon my own request.

INITIALS **X:** \_\_\_\_\_

**OUR COMMUNICATION POLICY**

It is the policy of Grand Haven Foot & Ankle to call patients and remind them of scheduled appointments 24-72 hours prior to their appointment time. The reminder calls only state patient’s name, date and time of the appointment, and the name of the doctor he/she will be seeing. Grand Haven Foot & Ankle may also call and leave a message requesting a return call from the patient or responsible party if there is private information that needs to be discussed.

INITIALS **X:** \_\_\_\_\_

**PATIENT ACKNOWLEDGMENT OF POLICY**

I hereby authorize Grand Haven Foot & Ankle to leave messages relating to my health care and appointments on my answering machine, with the responsible party who is listed, with family members who answer the phone at my residence, or with the responsible party who is listed in my medical record.

I understand that I may refuse to allow information to be communicated with certain friends and family members. Should that be the case, Grand Haven Foot & Ankle will provide me with proper form to complete in order to make my wishes known.

INITIALS **X:** \_\_\_\_\_

**TREATMENT CONSENT**

I hereby consent and give my permission to the doctor (and the doctor’s assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

INITIALS **X:** \_\_\_\_\_

**By signing below and initialing above, I have read and understand the information/policies/and consents.**

**X:** \_\_\_\_\_  
SIGNATURE OF PATIENT NAME OR PERSONAL REPRESENTATIVE

**X:** \_\_\_\_\_  
DATE

\_\_\_\_\_  
PLEASE PRINT PATIENT NAME OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

\_\_\_\_\_  
PATIENT’S DATE OF BIRTH

# Health History



PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR TODAY'S VISIT / PRIOR TREATMENT \_\_\_\_\_

ALLERGIES: (CIRCLE ALL THAT APPLY) PENICILLIN CODEINE SULFA ASPIRIN LOCAL ANESTHETIC  
OTHER (EXPLAIN): \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

MEDICAL CONDITIONS AND SURGERIES \_\_\_\_\_

TOBACCO? YES NO IF YES, PPD \_\_\_\_\_ ALCOHOL? YES NO IF YES, DRINKS/DAY \_\_\_\_\_

DRUG ABUSE? YES NO SPECIAL DIET? (LIST): \_\_\_\_\_

<b>REVIEW OF SYSTEMS</b> Circle all that you have had, or now have, problems related to the following.			
Chills / Fever Dizzy spells Excessive thirst Hot / Cold flashes Tired / Sluggish	Blindness Blurred vision Double vision Vision impairment	Corns / callouses Nail problems Open sores Skin rash	Alzheimer's disease Anxiety Dementia Depression Memory loss
Blood clotting problem Chest pain Cold feet High blood pressure Varicose veins	Abdominal pain Heartburn Indigestion Nausea	Ear infection Hearing loss Sinus problems Sore throat	Shortness of breath Frequent cough Wheezing
Diabetes	Frequent urination Difficulty urinating Painful urination	Aches / back pain Joint pain / neck pain Limitation of motion Weakness	
Drug allergies Hay fever	Numbness / tingling Tremors		

<b>FAMILY HISTORY</b>	YES	NO	RELATIONSHIP
Diabetes			
Cancer			
High blood pressure			
High cholesterol			
Heart disease			
Other:			

X: \_\_\_\_\_  
SIGNATURE OF PATIENT NAME OR PERSONAL REPRESENTATIVE

X: \_\_\_\_\_  
DATE



PATIENT NAME \_\_\_\_\_

## How did you hear of us?

- Yellow pages
- Internet
- Referring Doctor, if so, who? \_\_\_\_\_
- Friend, if so, who? \_\_\_\_\_
- Drive by / sign
- Westshore Health Network
- Hospital
- Radio
- Television
- Newspaper
- Chamber of Commerce
- Restaurant Placemat
- Was a patient of Dr. Meyer
- Other: \_\_\_\_\_

**THANK YOU!**