Andrea Simons, DPM
Davina Cross, DPM
13105 Schavey Road, Suite 2, DeWitt, MI 48820
(517) 668- 6166

Patient History

Today's Date: _______________

Date of Birth: ________________ Social Security #: ______________________

Name: ____
(First) (MI) (Last)

Prefers to be called____

Address: ____
(Street) (City) (State) (Zip)

Home Phone: ___________________ Work Phone: _____________________
Cell Phone: _____________________ Preferred Phone:___________________

Email: ____

Employer: ______________________ Occupation: ______________________

Marital Status: ____________________ Spouse's name: _____________________

Guardian's name (if patient is a minor): ____________________________________
Address (if different from above): ____
(Street) (City/State/ZIP)

Person to contact in case of an emergency: __________________________________
Relationship to patient: _________________ Phone: ______________________
Address: ____
(Street)
____
(City) (State) (Zip)

Referred By: ____

(Please Circle)

Race: African American, American Indian/Alaskan, Native Asian, Pacific Islander, White, **Other/Decline to Disclose**

Ethnicity: Hispanic/Latino, Non-Hispanic/Latino, **Decline to Disclose**

What is your foot or ankle problem? ____
____

When did the problem start? ____

How have you treated the problem? ____
____
____

Weight: ___________ Height: ____________ Shoe Size: _____________

Are you in: ( ) good health ( ) fair health ( ) poor health

Are you prone to prolonged bleeding or healing difficulties? ( ) yes ( ) no

Do you bruise easily? ( ) yes ( ) no

Primary Care Physician's name and address: _____________________________________
____

Last time you saw your Primary Care Physician ___________________________________

What medications are you currently taking? (If you have a list with you, we can copy the list.)

Name	Dose	Frequency

Are you allergic to any medications? ____
If yes, which ones? ____
Preferred Pharmacy? ____

Are you pregnant? ( ) yes ( ) no
Do you smoke? ( ) yes ( ) no If yes, how much? __________
Do you drink alcohol? ( ) yes ( ) no If yes, how much? __________
Do you take any illicit drugs? ( ) yes ( ) no If yes, which ones? __________

Do you have a family history of:

Diabetes	( )	Blood clots/Bleeding Disorder	( )
Heart disease	( )	Problems with anesthesia	( )
Cancer	( )	Hypertension	( )
Peripheral Arterial Disease	( )	Other	( )

____

Past Medical History (Do you currently or have you ever had any of the following):

Heart Disease	( )	Asthma	( )	High Cholesterol	( )
Neuropathy	( )	Anemia	( )	Stomach ulcer/GERD	( )
Hypertension	( )	Stroke	( )	Kidney Disease	( )
Bleeding Disorder	( )	Blood Clot	( )	Liver Disease	( )
Pneumonia	( )	Diabetes	( )	Epilepsy	( )
Thyroid Disease	( )	Venereal Disease	( )	Arthritis	( )
Gout	( )	Tuberculosis	( )	Eye Disease	( )
Pregnancy	( )	HIV	( )	Cancer	( )

Type__________________

Other____
____
____

Diabetic History:
Type: ____________ Date of Onset: ________________________
Complications due to Diabetes? ____
____

Past Surgical History: ____
____
____
Problems with anesthesia? ____

Is there anything else you feel we should know? ______________________________
____
____

I hereby give permission to Dr. Andrea Simons and Dr. Davina Cross to treat and/or photograph my foot.

Date: ____________________ ________________________________
Signature of Patient or Guardian

Insurance Information

Do you have a copay? Yes or No If yes, fill in amount here $____________

Primary Insurance Company	
Policy Holder	SSN#
Your Relationship to the Policy Holder	
Enrollee ID# or Medicare Claim Number	Group #
Subscriber's Employer	
Policy Holder's Birthdate	
Secondary Insurance Company	
Policy Holder	SSN#
Your Relationship to the Policy Holder	
Enrollee ID#	Group #
Subscriber's Employer	
Policy Holder's Birthdate	

Release and Assignment of Benefits

I hereby authorize the release of any medical information necessary to process my insurance claim. I authorize payment to be made directly to Looking Glass Foot & Ankle Center, P.C., tax ID # 27-2516761. I have been provided with a copy of the Looking Glass Foot & Ankle Center Financial Policy and understand that I am financially responsible for any and all balance(s) not covered by insurance carriers or out-of-pocket expenses at the time of service.

______________________________ ____________

Signature Date

Patient Name: ______________________________Date of birth_____________________
(Please Print)

PAYMENT
I acknowledge that I have been offered the Financial Policy and I acknowledge it is my responsibility to pay for any services I receive from Looking Glass Foot and Ankle Center.

____
Signature Date

MEDICARE PATIENTS ONLY
I authorize and request that payment of authorized Medicare benefits be made to Looking Glass Foot and Ankle Center on my behalf for any services furnished to me by a provider of Looking Glass Foot and Ankle Center.

____
Signature Date

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DO YOU HAVE AN ADVANCED DIRECTIVE? Yes No
For more information regarding Advanced Directives please visit www.caringinfo.org

LOOKING GLASS FOOT AND ANKLE CENTER NOTICE OF PRIVACY PRACTICE

I acknowledge that I have been offered the Looking Glass Foot and Ankle Center Notice of Privacy Practices

__________________________ ____________________________ ___________
Patient Name (please print) Signature Date

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COMMUNICATION OF YOUR PROTECTED HEALTH INFORMATION
If you want us to speak with another individual **including your primary care physician** about your care, please list their name, relationship to you, and phone number:

Name Relationship Phone Number

____
Signature