7305 Midland Rd Suite #2
Freeland, MI 48623

www.FreelandFoot.com
Ph: (989) 695-6788 Fax: (989) 695-6491

At Freeland Foot and Ankle Clinic we are committed to getting you back on your feet and back into life!
We understand that when your feet hurt you hurt all over and stop doing the things you love.
We provide the best conservative foot care with the most up to date technologies to stop the pain and prevent the injuries which most often begin in the feet!
Thank you for giving us the opportunity to serve you.

Full name:_____ Today's Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Marital Status: S M W D

Address: _____ Primary Phone #: (_____) _____

City: _____ State: _____ Zip: _____ Secondary Phone #: (_____) _____

E-mail address _____

Occupation: _____ If retired, your former occupation: _____

Patient's Employer: _____ Business Phone: (_____) _____

Spouse: _____ Are they our patient? Yes / No

If under 18 y/o, name of parent/guardian: _____

Relationship to Patient: _____ Responsible parties DOB: _____

How did you hear about our practice? _____

If you were referred by someone, please leave their name so we can thank them: _____

In case of emergency, notify: _____ Relationship: _____

Phone #1: (_____) _____ Phone #2: (_____) _____

Primary Physician: _____ Last visit: _____

Former Podiatrist Name: _____ Last visit: _____

Other Physician: _____ Last visit: _____

PHARMACY: _____

Reason for visit: _____

In the last few months has there been a change in your:

Weight Work Activity Shoes Flooring at work or home

Height_____ Weight_____ Shoe Size_____

Please list or provide a copy of your prescribed and/or over the counter medicine: _____

_____

_____

Please list your allergies: _____

Do you have any FOOT or ANKLE pain? Yes No Right Left Both

If yes, please explain: _____

Do you have any KNEE, HIP or BACK pain? Yes No Right Left Both

If yes, please explain: _____

Do any of the above problems limit your ability to:
Walk? Yes No Wear shoes? Yes No Work? Yes No

Do you wear or have you worn inserts for your shoes? Yes No Prescribed Over the counter

Do you have any of the following:

Diabetes	Cancer: _____	Swelling
Kidney Disease	Gout	Broken Bones
Liver Disease	Reynauds	Ulcer / Wound
Arthritis	Neuropathy / Numbness	Cramps
Blood Clot	Poor Circulation	Rash
Bleeding Disorder	Other _____	Dry Skin

Any of these on Feet or Legs:

If you are diabetic please provide additional details below.

Do you use insulin? Yes No What was your most recent Blood sugar _____

When was your most recent A1C?_____ What was it?_____

Provider who follows your Diabetic care:_____ Date you were last seen?_____

Please list any FOOT, ANKLE, KNEE or BACK surgeries with approximate date: _____

_____

Insurance Information / Consent / Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediary or carriers, or to the billing agent of Freeland Foot and Ankle Clinic, any information needed for this claim. I permit a copy of this authorization to be used in place of the original. I authorize the release of my medical records to and /or from my physician or other health care providers.

I understand that I am responsible for payment of charges related to services provided. I also understand that when payment is not made or arrangements for payment are not made by 90 days my balance will be sent to an outside collection company and a 35% charge will be added to my account.

Patient / Guardian initial: _____

Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to: Freeland Foot and Ankle Clinic for any service furnished to me by the physician.

Patient / Guardian initial: _____

Office Cancellation / No Show Policy

Please keep all appointments or call to change an appointment with 24 hour notice.
I understand that after a missed appointment one reschedule will be allowed. If additional missed appointments occur a $30 deposit will be required prior to scheduling another appointment.

Patient / Guardian initial: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have had the opportunity to read the Notice of Privacy Practices and that I have been offered a copy. It is my understanding that if I have a question, I may contact Freeland Foot and Ankle Clinic for more information.

Patient / Guardian initial: _____

_____ _____
Patient Name (please print) Date

_____ _____
Parent or Guardian Name (if applicable) Signature