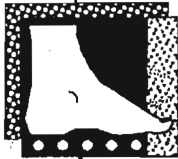

MACOMB FOOT, ANKLE, & WOUND CARE CENTER

WALTER B. COLEMAN, D.P.M.* KYLE W. SUNDBLAD, D.P.M.

*FELLOW - AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS
*DIPLOMATE - AMERICAN BOARD OF PODIATRIC SURGERY

WELCOME TO OUR OFFICE

NAME ____
Last First

ADDRESS ____
Street Apt# City State Zip

HOME PHONE (____)__________WORK PHONE (_____)__________EMAIL__________

AGE ____BIRTHDATE__________ SS# ___-____-___DRIVER'S LICENSE #__________

SEX ________HEIGHT__________WEIGHT ___________SHOE SIZE __________

YOUR OCCUPATION ________________ EMPLOYER ________________

EMPLOYER'S ADDRESS ______________________________________

EMERGENCY CONTACT ____________________ (____)______________
NAME PHONE

MARITAL STATUS (CIRCLE) S M W D NAME OF SPOUSE ________________

DO YOU HAVE HEALTH INSURANCE ☐ YES ☐ NO (If yes, we'll need to copy your card (s).

INSURANCE COMPANY NAME______________________________

CARD HOLDERS NAME ________________ DATE OF BIRTH __________

CONTRACT # ______________________GROUP#______________

MEDICARE # ______________________MEDICAID # ______________

**If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms is the patient's responsibility.

ALL UNPAID BALANCES AND/OR DENIED CLAIMS ARE YOUR RESPONSIBILITY.

DOCTOR'S NAME ______________PHONE # __________DATE OF LAST VISIT______

WHO REFERRED YOU TO OUR CARE?______________________________

WHAT IS YOUR FOOT PROBLEM? ______________________________

WHEN DID THE PROBLEM START ______**HAVE YOU BEEN TREATED FOR ?☐ YES☐ NO**

BY WHOM?____________________**IS THIS WORK RELATED INJURY? ☐ YES ☐ NO**

586/979/0560 PHONE

9001 Fifteen Mile Road • Sterling Heights, MI 48312

586/979/8766 FAX

MEDICAL INFORMATION

Family History

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

☐ Heart Disease ________________ ☐ Circulatory Disease ____________ ☐ Neurological Problems ________
☐ Cancer ____________________ ☐ Hypertension ________________ ☐ Skin Disease ______________
☐ Diabetes ___________________ ☐ Arthritis ____________________ ☐ Foot Problems _____________

Additional space, if necessary ____

Review of Systems

Please indicate any personal history below, circle:

- Constitutional Symptoms
  - Good general health lately ....yes no
  - Recent weight change...............yes no
  - Fever....................................yes no
  - Fatigue.................................yes no
  - Headaches.............................yes no
- Eyes
  - Eye disease or injury................yes no
  - Wear glasses/contact lenses.........yes no
  - Blurred or double vision.............yes no
- Ears/Nose/Mouth/Throat
  - Hearing loss or ringing...............yes no
  - Earaches or drainage..................yes no
  - Sinus problems..........................yes no
  - Nose bleeds..............................yes no
  - Mouth sores.............................yes no
  - Swollen glands in neck................yes no
- Cardiovascular
  - Heart trouble ....yes no
  - Chest pain or angina...................yes no
  - Palpitation...............................yes no
  - Shortness of breathe w/exertion......yes no
  - Swelling of feet, ankles or hands....yes no
- Respiratory
  - Chronic or frequent coughs.............yes no
  - Spitting up blood.........................yes no
  - Shortness of breathe.....................yes no
  - Wheezing.................................yes no
- Gastrointestinal
  - Loss of appetite..........................yes no
  - Nausea or vomiting.....................yes no
  - Frequent diarrhea.........................yes no
  - Rectal bleeding or blood in stool......yes no
  - Abdominal pain..........................yes no
- Genitourinary
  - Frequent urination......................yes no
  - Burning or painful urination...........yes no
  - Blood in urine...........................yes no
  - Female - # of pregnancies............______
  - Female - # of mischarriages...........______
- Musculosketetal
  - Joint pain................................ yes no
  - Joint stiffness or swelling...............yes no
  - Weakness or muscles or joints.........yes no
  - Muscle pain or cramps..................yes no
  - Back pain.................................yes no
  - Cold extremities..........................yes no
  - Difficulty in walking....................yes no
- Integumentary (skin)
  - Rash or itching..........................yes no
  - Change in skin color....................yes no
  - Change in hair or nails.................yes no
  - Varicose veins...........................yes no
- Neurological
  - Frequent or recurring headaches......yes no
  - Light headed or dizzy..................yes no
  - Convulsions or seizures.................yes no
  - Numbness or tingling sensations......yes no
  - Tremors..................................yes no
  - Paralysis or weakness..................yes no
  - Head injury...............................yes no
- Psychiatric
  - memory loss or confusion............yes no
  - Nervousness..............................yes no
  - Depression...............................yes no
  - Insomnia..................................yes no
- Endocrine
  - Glandular or hormone problem.......yes no
  - Excessive thirst or urination..........yes no
  - Heat or cold intolerance...............yes no
  - Skin becoming drier....................yes no
  - Change in hat or glove size............yes no
- Hematologic/Lymphatic
  - Slow to heal after cuts..................yes no
  - Bleeding or bruising tendency.........yes no
  - Anemia....................................yes no
  - Phlebitis...................................yes no
  - Past transfusion..........................yes no
  - Enlarged glands..........................yes no

Allergies

Do you have a history of skin reaction or other adverse reaction to:

☐ Anesthetics ☐ Environmental Substances ☐ Pain Medication ☐ Sulfa
☐ Antibiotics ☐ Foods ☐ Penicillin ☐ Tape
☐ Aspirin ☐ Iodine ☐ Seasonal allergies ☐ Tetanus
☐ Codeine ☐ IV Dye ☐ Silver ☐ Other______

Specify above and any others:____

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I, hereby, give my permission to Macomb Foot, Ankle, & Wound Care Center to diagnose and administer treatment of my foot condition.

Signature______________________ Date____________________ Reviewed by:______________

MEDICAL INFORMATION

Past Medical History

- ☐ Measles
- ☐ Mumps
- ☐ Chickenpox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Smallpox
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ AIDS or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Balance Problems
- ☐ Liver Disease
- ☐ Bladder Problems
- ☐ Bowel Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ear/Nose/Throat problems
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fever over 103°
- ☐ Heart Disease
- ☐ High/Low Blood Pressure
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Blood/Plasma Transfusions
- ☐ Other ______________________________
- ☐ Numbness/Tingling
- ☐ Pacemaker
- ☐ Polio
- ☐ Prolonged Bleeding
- ☐ Psychological Problems
- ☐ Sexually Transmitted Disease
- ☐ Skin Problems
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Ulcer
- ☐ Varicose Veins
- ☐ Vision Problems
- ☐ Migraine Headaches

Previous Hospitalizations/Surgeries/Serious Illness (and When?) ______________________________

____

____

What Medications &/or vitamins are you taking now and what dose? ______________________________

____

____

(Women) Are you pregnant? ☐ Yes ☐ No Are you taking Birth Control Pills? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason (s)? ______________________________

____

Social History

Do you live alone? ☐ Yes ☐ No For how long?______________

Do you have children? ☐ Yes ☐ No If yes, How many? __________

Do you exercise? ☐ Yes ☐ No If yes, how often?_____What kind of exercise?_____

Are you on a special diet? ☐ Yes ☐ No If yes, what kind?______________________________

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? #__for #____years

If no, when did you quit?_____ How many packs had you smoked?#_____per day for # _____years

Do you drink alcohol? ☐ Yes ☐ No How much ___Daily ___Weekly ___Monthly ___Yearly

Do you have a history of substance abuse? ☐ Yes ☐ No What Substance? ______________

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Macomb Foot, Ankle, & Wound Care Center and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs.

________.
(initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purpose of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

________.
(initial)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I, authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorneys fees. ________.
(initials)

Patient or Authorized Person Signature	Relationship	Date