

Brighton Foot and Ankle - 7990 Grand River Avenue, Suite D Brighton, MI 48114

To submit prior to appointment send via email: info@brightonfootandankle.com or fax 810-958-1174

Patient Last Name	Patient Legal First Name	Middle Initial
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Patient Date of Birth ____/____/____	Patient Social Security # ____-____-____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
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Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	Race <input type="checkbox"/> Not Specified <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White	Ethnicity <input type="checkbox"/> Not Specified <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
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Street (No PO BOX):	City	State	Zip
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Home Phone (____) ____-____	Cell Phone (____) ____-____	Email for Patient Portal _____
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I understand that the above information will be used to contact me regarding appointments, treatment and billing matters. I agree to phone, text and email communications from this office, with the understanding that I can opt out of text (Msg & Data rates may apply) and emails if I so choose.

Occupation _____	Employer _____
Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed	<input type="checkbox"/> Student

Emergency Contact Name _____	Relationship <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____	Best Phone Number (____) ____-____
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Family Doctor _____	Town _____	Office Phone: (____) ____-____
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How did you hear about our office?

What brings you in today (be specific): _____	Duration _____
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Primary Ins. Carrier: _____	Secondary Ins. Carrier: _____
Name of policy holder: _____	Name of policy holder: _____
Policy Holder DOB: _____	Policy Holder DOB: _____

Is your claim Auto or Work Comp <input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, Date of Injury _____	Claim Number _____	Claim Rep Name _____	Rep Phone # _____
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Medicare Only: Are you enrolled in Hospice Y/N Do you receive Home Health Care Y/N Do you live in a nursing home Y/N

Privacy Information

Where may we contact/leave you message(s):	HOME <input type="checkbox"/> YES <input type="checkbox"/> NO	CELL <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of person(s) who can have access to your records/PHI or pick up items for you:		
Name _____	Relationship _____	
Name _____	Relationship _____	
Name _____	Relationship _____	

Attest

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Brighton Foot and Ankle immediately of any changes to the above information and annually upon the office's request. I also acknowledge that I have been provided the opportunity to take and review the office's HIPAA Policy version 1/1/17, Authorization from Patient or Legal Representative version 1/1/17, and Notification of Office Policies and Procedures version 1/1/17. (available in our waiting room and/or by request). I further acknowledge and accept all the terms and conditions outlined in all forms listed including "notifications of office policies and procedures", "HIPAA policy notice of privacy practices", and "authorization from patient or legal representative".

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CURRENT MEDICAL HISTORY

Patient Last Name _____ **Patient Legal First Name** _____

Patient Shoe Size _____ **Weight** _____ **Height** _____ **Is Patient Diabetic** Yes No

Physician that follows your diabetic care _____ **Date last seen by PCP** _____

Current Conditions – mark NONE if the condition below does NOT apply to you

Symptoms: <input type="checkbox"/> None <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	Neurological: <input type="checkbox"/> None <input type="checkbox"/> Numbness/ Nerve Pain <input type="checkbox"/> Seizures <input type="checkbox"/> Strokes
Skin: <input type="checkbox"/> None <input type="checkbox"/> Cellulitis/Infection <input type="checkbox"/> Fungal Nails <input type="checkbox"/> Ingrown Nails <input type="checkbox"/> Sores <input type="checkbox"/> Rash <input type="checkbox"/> Warts	Vascular: <input type="checkbox"/> None <input type="checkbox"/> Leg/Calf Cramping <input type="checkbox"/> Cold Feet <input type="checkbox"/> Leg/Calf Cramping at rest <input type="checkbox"/> Skin red/ pale / purple

Allergies – mark NONE if the allergies below do not apply to you

None Adhesive/tape Anesthetics Aspirin Blood thinners Codeine Dairy Eggs Erythromycin
Demerol IV contrast dye Iodine Latex Penicillin Seafood Sulfa Other: _____

Current Medications

Medication List can be copied & attached separately if available – You do NOT have to rewrite medications

Medication	Dosage	How Often	Medication	Dosage	How Often
<input type="checkbox"/> None			_____		
_____			_____		
_____			_____		

Pharmacy you prefer to use

Pharmacy: _____ **Crossroads:** _____ **Zip/City:** _____

Past Medical History – mark NONE if the history below does NOT apply to you

<input type="checkbox"/> None	<input type="checkbox"/> CAD	<input type="checkbox"/> Gastric reflux	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cancer (Type) _____	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Skin disease
<input type="checkbox"/> Abnormal heart beat	<input type="checkbox"/> Chronic back pain	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Hepatitis (Type____)	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Ulcers/Sores
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Dementia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Parkinson’s disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatoid arthritis/ autoimmune disease	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease			

Social History

Family History

Smoking History <input type="checkbox"/> Non Smoker <input type="checkbox"/> Current Smoker Packs per day _____ <input type="checkbox"/> Former smoker Years of cessation _____	Alcohol History <input type="checkbox"/> None <input type="checkbox"/> Social <input type="checkbox"/> Occasional <input type="checkbox"/> Heavy	Place An “X” on all applicable lines No significant family medical conditions _____ Unknown family history _____ Diabetes _____ Heart Attack _____ Cancer _____ Other _____	Father _____ Mother _____ Both _____
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Peripheral Artery Disease (PAD) Questionnaire and Fall Questionnaire

Patient Last Name	Patient Legal First Name	Middle Initial	DOB
Do your legs ever feel tired causing you to stop and rest?		Yes	No
When you walk do you ever have to stop because you have pain or cramping in your calves or thighs?		Yes	No
Do you ever experience cramping, tightness, “charlie horses” or pain in the legs or feet when lying down that improves when you stand up?		Yes	No
Do you have any wounds, cuts, or sores that are not healing on your feet or toes?		Yes	No
Is the skin on your legs or feet pale, reddish or purple?		Yes	No
Is the skin on your legs or feet cool to the touch?		Yes	No
Have you ever been told you have diabetes? Even borderline diabetes?		Yes	No
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication or peripheral arterial disease?		Yes	No
Have you ever had any testing done to your legs for these diseases?		Yes	No

Do you use a walker, cane, or other assistive device when walking?		Yes	No
Do you feel unstable when you walk?		Yes	No
Have you fallen in the past, or had a “near fall” in past?		Yes	No

Print Patient’s Name or Legal Representative Signature Relationship to Patient Date

