GREAT LAKES
FOOT & ANKLE INSTITUTE

Patient Registration

Patient Name:_____ _____ _____ Date_____
Last First M

Date of Birth: _____/ _____/ _____ Social Security Number:_____
Address: _____ City: _____
State: _____ Zip Code_____
Preferred Phone Number: _____Secondary Phone Number:_____
Email Address: _____

Sex: ☐Male ☐Female
Marital Status: ☐Single ☐ Married ☐ Widowed ☐ Divorced ☐Separated
Ethnicity/Race: ☐ American Indian/Alaska Native ☐Asian ☐Black or African American
☐ Hispanic or Latino ☐White ☐Other:_____

Do you require an interpreter? ☐No, I do not require an interpreter or I will provide my own. ☐Yes
If Yes, what type? ☐Sign Language ☐ Language:_____

Is this visit associated with a work injury? ☐Yes ☐No
If yes, please provide the following information:
Employer:_____
Employer Number and Person of Contact: _____
Adjuster's Name and Contact Information:_____
Claim Number: _____Date of Injury: _____
Is this visit associated with an auto accident? ☐Yes ☐No
If yes, please provide the following information:
Auto Insurance Provider:_____
Insurance Contact Name and Contact Information:_____
Claim Number: _____Date of Accident: _____

Primary Insurance Company Name: _____
Primary Insurance ID: _____
Primary Insurance Group Number: _____
Are you the Primary Subscriber on the policy? ☐Yes ☐No If no, who is?_____
Relationship to main subscriber_____

Secondary Insurance Company Name: _____
Secondary Insurance ID: _____
Secondary Insurance Group Number: _____
Are you the Primary Subscriber on the policy? ☐Yes ☐No If no, who is?_____
Relationship to main subscriber_____

GREAT LAKES
FOOT & ANKLE INSTITUTE

Emergency Contact Name:_____
Relationship to Patient:_____

How did you learn about our office?_____
Did a doctor refer you? ⬜Yes ⬜No If Yes, what doctor and specialty?:_____
_____

Primary Care Physician:_____
Primary Care Physician Address:_____
Primary Care Physician Phone Number:_____
Date Last Seen by Primary Care Physician:_____

Are you seeing a Speciality Physician? ⬜Yes ⬜No
Specialty Physician Name:_____
Speciality Physician Address:_____
Speciality Physician Phone Number:_____

Pharmacy Name:_____
If Mail Order Pharmacy, please provide local pharmacy as well.
Pharmacy Address:_____
Pharmacy Phone Number:_____

Current Medications:

Name_____Dosage_____Frequency_____Condition_____
Name_____Dosage_____Frequency_____Condition_____
Name_____Dosage_____Frequency_____Condition_____
Name_____Dosage_____Frequency_____Condition_____
Name_____Dosage_____Frequency_____Condition_____
Name_____Dosage_____Frequency_____Condition_____
Name_____Dosage_____Frequency_____Condition_____

Are you currently pregnant? ⬜Yes ⬜No
Are you currently breastfeeding? ⬜Yes ⬜No
Current Height _____ft_____in
Current Weight_____

GREAT LAKES
FOOT & ANKLE INSTITUTE

Medical History : Please check the appropriate box

Edema/Swelling	Yes_____No_____	Gout	Yes_____No_____
AIDS/HIV	Yes_____No_____	Arthritis	Yes_____No_____
Heart Disease	Yes_____No_____	High Cholesterol	Yes_____No_____
Cancer	Yes_____No_____ Type_____	Hepatitis	Yes_____No_____ A____B____C____
Diabetes	Yes_____No_____ Type: 1____2____ Blood Sugar_____ A1C_____ Last Eye Exam Date_____	Kidney Problems	Yes_____No_____ If yes: Stage:_____ Dialysis? Yes_____No_____
Heart Attack	Yes_____No_____	Anxiety	Yes_____No_____
High Blood Pressure	Yes_____No_____	Stroke	Yes_____No_____
Circulation Problems	Yes_____No_____	Rheumatic Fever	Yes_____No_____
Seizures/Epilepsy	Yes_____No_____	TB	Yes_____No_____
Stomach Ulcers	Yes_____No_____	Varicose Veins	Yes_____No_____
Diabetic Foot Ulcers	Yes_____No_____	Thyroid Problems	Yes_____No_____
Alzheimer's/Dementia	Yes_____No_____	Chemotherapy	Yes_____No_____
Memory Loss	Yes_____No_____	Anemia	Yes_____No_____
Asthma	Yes_____No_____	Neurological Illness	Yes_____No_____
Blood Clots/DVT	Yes_____No_____	Heart Murmur	Yes_____No_____
Pulmonary Embolism	Yes_____No_____	Vitamin Deficiency	Yes_____No_____
Fibromyalgia	Yes_____No_____	Bleeding Disorder	Yes_____No_____
Parkinson's	Yes_____No_____	Clotting Disorder	Yes_____No_____
Heartburn	Yes_____No_____	Liver Disease	Yes_____No_____
COPD	Yes_____No_____	Rheumatoid Arthritis	Yes_____No_____
Asthma	Yes_____No_____		

Allergies

⬜Medications_____ ⬜Anesthesia_____
⬜Foods_____ ⬜Other_____
⬜Tape ⬜Latex ⬜Iodine ⬜Shellfish
⬜None (no known allergies)

_____

GREAT LAKES
FOOT & ANKLE INSTITUTE

List any past surgeries and their corresponding date:

_____
_____
_____
_____

No past surgeries: ⬜

List any past hospitalization dates other than surgery:

_____
_____
_____
_____

No past hospitalizations: ⬜

Family History : ⬜Patient is Adopted- Family History is Unknown

Family Member	Alive Deceased Unknown	Age	Diabetes	Hypertension (High Blood Pressure)	Heart Disease	Cancer	Stroke	Coronary Artery Disease	Rheumatoid Arthritis	Thyroid Disease	Unknown
Father											
Mother											
Siblings											
Daughter (s)											
Son (s)											
Grandfather											
Grandmother											
Uncle											
Aunt											
Spouse											

Social History

Tobacco/E-Cigarette Use	Never ⬜ Former⬜ Date Quit_____ Current⬜ Type_____ Frequency_____
Alcohol Use	Never ⬜ Former⬜ Date Quit_____ Current⬜ Frequency:Rare⬜Occasional ⬜Moderate ⬜Daily⬜ Type_____
Drug Use	Never ⬜ Former⬜ Date Quit_____ Current⬜Type_____ Frequency_____

GREAT LAKES
FOOT & ANKLE INSTITUTE

Current Problem

What problem brings you to our office today?_____

How long ago did this problem first start?_____ Days Weeks Months Years

Was your pain or problem: Begin Suddenly Gradually developed overtime

How would you describe your pain? No pain Sharp Dull Aching Burning Radiating Itching Stabbing Other_____

How would you rate your pain on a scale from 0 to 10?_____

Since the onset of your pain/problem has it: Stayed the same Gotten Worse Improved

What makes your pain/problem worse?

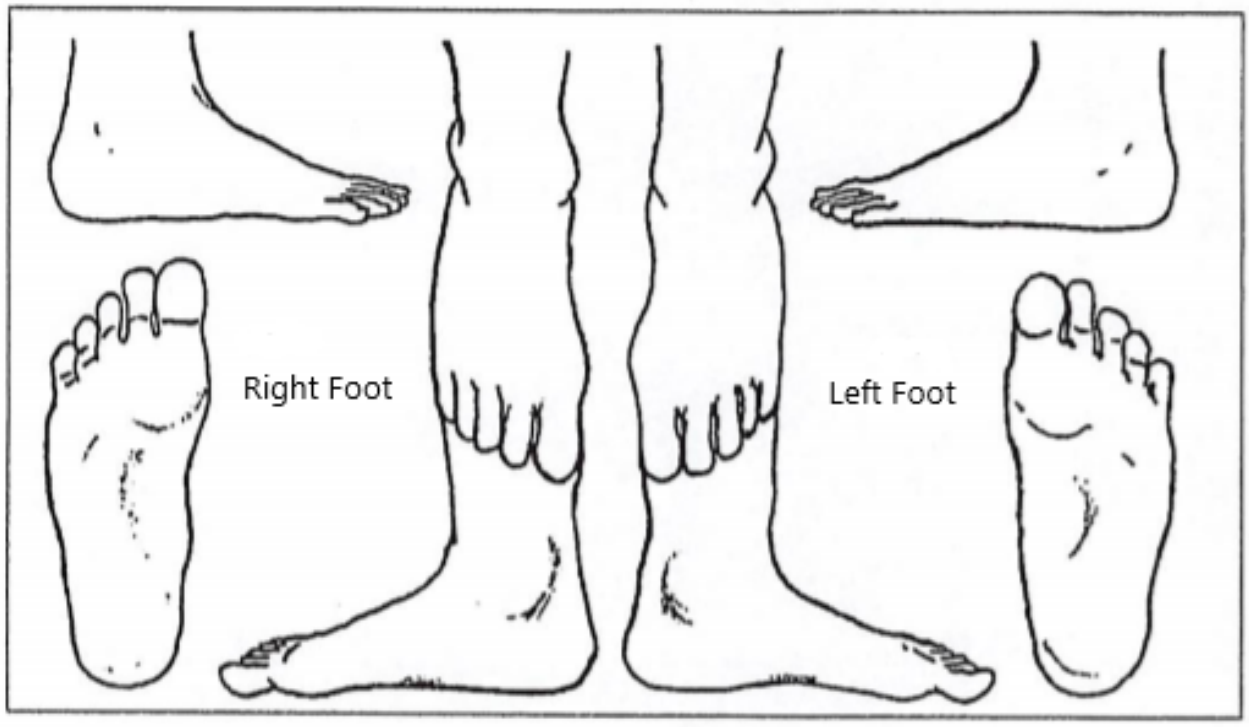
Running Dress Shoes High Heels Flat Shoes Any Closed Toe Show Other_____

What makes your pain/problem feel better?_____

What treatments have you had for this problem?_____

How has this problem affected your lifestyle or ability to work?_____

Circle your area of concern(s) below:



GREAT LAKES
FOOT & ANKLE INSTITUTE

I hereby authorize Great Lakes Foot and Ankle Institute to treat me in any way that is appropriate and furnish information to my insurance carrier concerning my illness and treatment. To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status. I agree that Great Lakes Foot and Ankle Institute may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. I hereby assign to the physician all payment for medical services rendered to me and my dependents. I understand that I am responsible for any medical bills not paid by my insurance carrier.

_____	_____	_____
Printed Name of Patient, Parent, or Guardian	Signature of Patient or Representative	Date

_____
If other than patient, relationship to patient

GREAT LAKES
FOOT & ANKLE INSTITUTE

Patient HIPAA Acknowledgement and Designation Disclosure Form

I. **Acknowledgement of Practice's Notice of Privacy Practices:**
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practice (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Guardian	Today's Date

II. **Designation of certain relatives, close friends, and other caregivers as my personal representative:**
I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing; since such a person is involved with my healthcare or payment relating to my healthcare. In that case, the physician practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Name printed: _____ Date of Birth_____

Name printed: _____ Date of Birth_____

Name printed: _____ Date of Birth_____

V. The **HIPAA** Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the practice does not have to account for disclosures for which I have executed an authorization permitting disclosures of my PHI.

Name of Patient	Signature of Patient	Today's Date

GREAT LAKES
FOOT & ANKLE INSTITUTE

E-Prescribing Consent Form

ePrescribing is defined by a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:
Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Great Lakes Foot & Ankle Institute can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Great Lakes Foot & Ankle Institute to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will expire one year from the date it is signed.

⬜ I Accept

⬜ I Decline

Date:_____

GREAT LAKES
FOOT & ANKLE INSTITUTE

Coordination of Care Consent

As a part of your Patient-Centered Medical Home Neighborhood, we welcome you to our Specialty Practice!

We are partnering with your Primary Care Physician (PCP) who is your Patient Centered Medical Home. We are sharing their commitment to effectively and efficiently work together to manage your care. As your Specialist, we will be sharing information about your condition and provide recommendations, guidance and periodic follow-up.

A Patient-Centered Medical Home - neighborhood (PCMH-n) is a system of care in which a team of health professionals work together to provide your entire healthcare needs. You, the patient, are the most important part of the PCMH-n. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

We trust you as our patient to:

· Keep your appointments as scheduled, or call and let us know when you are unable to keep your appointment.
· Seek the advice of your PCP before you see other physicians.
· Follow the care plan that is agreed upon-or let us know why you cannot follow the plan so we can try to help you.
· Tell us what medications you are taking.
· See your PCP for all preventive services

As your Specialist I will:

· Communicate with your Primary Care Physician (PCP) and provide timely written reports.
· Notify your PCP of no-shows, cancellations and other actions that may place your care in jeopardy.
· Notify your PCP if you are being referred to another specialist
· Remind you of tests due and inform you of your test results
· End every visit with clear instructions about expectations, treatment goals, and how I will coordinate with your Primary Care Provider.

Coordination of care and communication back to your PCP is my priority. Should you have other physicians managing your care please inform them that I am the specialist managing your foot or ankle condition and that I require communication regarding any treatment that may affect my treatment plan.

⬜ I Accept

⬜ I Decline

Date:_____