West Michigan Foot and Ankle PLLC
Alexus Squires DPM, AACFAS

Demographics

First Name:_____ Last Name: _____ DOB: _____/_____/_____

Preferred Name: _____ Gender: _____ Age: _____ Shoe Size: _____

SSN (optional) #:_____-_____-_____ Email*: _____

*Providing an email address will automatically sign the email up for West Michigan Foot and Ankle Reminders & Marketing unless otherwise specified

Cell Phone: _____ Home Phone: _____

Address:_____

City: _____ State: _____ Zip: _____

Were you referred by one of our patients? Yes ⬜ No ⬜

If Yes, who referred you? We want to thank them! _____

Marital Status: Single ⬜ Married ⬜ Divorced ⬜ Widowed ⬜

Occupation:_____

Emergency Contact Full Name: _____

Phone Number: _____ Relationship:_____

Primary Care Doctor: _____ Date Last seen: _____

Name of Pharmacy: _____ City/Zip Code: _____

Primary Insurance Company Name: _____

Secondary Insurance Company Name: _____

Please provide cards to the receptionist so we can copy them to your patient chart.

Responsible Party: Name _____ DOB _____/_____/_____

Social Security Number_____ (The person who supplies the patient's insurance or who is responsible for payment if uninsured).

Phone Number: _____ Relation to Patient: _____

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Medical History

Patient First Name: _____ Patient Last Name: _____

Height: _____ Weight:_____ Pain Level (0-10): _____

MEDICATIONS Please list all medications and dosages **OR** give a list to the front desk:

Medication Name:	Dosage	Medication Name:	Dosage
1.		4.	
2.		5.	
3.		6.	

ALLERGIES: ⬜ No known drug allergies **OR** Please list any allergies with reaction below:

Drug/Environmental/Food Allergy:	Reaction:

MEDICAL HISTORY Check those that apply to you now or have applied to you in the past:

	Diabetes: Average Blood Sugar: _____ Last A1C: _____ ⬜ Type I ⬜ Type II		Multiple Sclerosis
	Peripheral Neuropathy		Raynaud's Syndrome
	Celiac Disease		Sexually Transmitted Disease
	Liver Disorder		Drug/Alcohol Abuse
	Kidney Disease		Epilepsy or Seizures
	Dialysis		Stomach/Ulcer Disorder
	Frequent Headache/Migraines		Thyroid/Parathyroid Disease
	Asthma		High Blood Pressure
	Emphysema		Arthritis
	Heart Trouble **Please specify:** _____		Psychiatric Treatment
	Stroke		Difficulty Healing
	Gout		Hepatitis/HIV
	Blood clots		Anemia/Blood Disorders
	Ear, Nose, Throat Disorder		Other:

Please list any other specific health concerns: _____
_____
_____

SURGICAL HISTORY

Surgical Procedure	Year	Physician	Hospital

FAMILY HISTORY has any **family member** had any of the following (please indicate relationship):

Cancer:	Diabetes:
Heart Trouble:	High Blood Pressure:
Kidney Disease:	Bleeding Disorders:
Stroke:	Blood Clots:
Arthritis:	Other:

SOCIAL HISTORY

Do you smoke currently? Yes ⬜ No ⬜ If yes, how much per day? _____

Do you drink alcohol? Yes ⬜ No ⬜ If yes, what and how often? _____

Do you use recreational drugs? Yes ⬜ No ⬜

Are you currently experiencing any of the following? Check all that apply:

Constitutional:	⬜ Weight Loss	⬜ Fever /Chills	
Eyes:	⬜ Visual changes		
Ears, Nose, Mouth, and Throat:	⬜ Hearing loss		
Cardiovascular:	⬜ Chest pain	⬜ Varicose veins	⬜ Peripheral edema.
Respiratory:	⬜ Cough	⬜ Shortness of Breath	⬜ Wheezing
Gastrointestinal:	⬜ Abdominal pain	⬜ Heartburn	
Genitourinary:	⬜ Frequent urination		
Musculoskeletal:	⬜ Joint Pain	⬜ Joint Swelling	
Integumentary:	⬜ Rashes	⬜ Sores	⬜ Blisters
Neurological:	⬜ Numbness	⬜ Tingling	⬜ Burning
Psychiatric:	⬜ Anxiety	⬜ Depression	
Endocrine:	⬜ Heat/cold intolerance		
Hematologic/Lymphatic:	⬜ Abnormal bleeding		
Allergic/Immunologic:	⬜ Recurrent infections		

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AUTHORIZATION FOR PEOPLE INVOLVED IN PATIENT'S CARE

I have the right to choose family members, friends or others to be involved in talks about my health care. The people listed below may receive any verbal information needed to be involved in my care or to help me make decisions about my care. By signing this form, I give permission for staff within West Michigan Foot and Ankle PLLC to discuss information about me with the people listed. The information discussed may include diagnosis, test results, medicine, treatment options and other information from previous services I have had, either in hospitals or other locations.

- I know that information may be discussed with family members or others without this form, if allowed by federal and state laws.
- I know that listing a person on this form does not allow them to get or copy my medical records.
- People listed on this form are not allowed to give consent for services for me.
- For a minor, parents are assumed to be designated except for those services which the minor has given consent under Michigan Law.

LIST PEOPLE THAT MAY RECEIVE VERBAL INFORMATION ABOUT YOUR CARE:

Name of Person	Relationship	Contact Phone Number(s)	Allowed To Receive Verbal Information About Your Care
			☐
			☐
			☐

The following information has special protection under Michigan Law and will be made available to the people listed above ONLY if I give my approval by checking the box(es) below AND initial the line(s).

_____ ☐ HIV/AIDS or other diseases - Tuberculosis, hepatitis, venereal diseases, sexually transmitted diseases.
_____ ☐ Substance abuse services
_____ ☐ Mental Health Services

I can update this form at any time by telling a WMFA staff member AND by filling out a new form. I can take away my permission to share my information at any time by putting that request in writing and giving that request to a WMFA staff member.

Patient Signature(s)
I have read this form and I understand it. All my questions have been answered.

TIME: _____ ☐AM/☐PM **DATE:** _____ **SIGNATURE:** _____

IF YOU ARE A PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN SIGNING FOR THE PATIENT:

PRINTED NAME OF PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN: _____

RELATIONSHIP TO PATIENT: _____

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APPOINTMENT AGREEMENT

PAYMENT POLICY:

Our team at West Michigan Foot and Ankle PLLC are committed to keeping you well-informed about your available financial options. We ask that insurance co-pays or out of pocket percentages are paid at the time of service. We accept cash, checks, and all major Credit Cards, including Care Credit. If you have any questions about your expected out of pocket or our financial options, please contact our office before your appointment.

APPOINTMENT CONFIRMATIONS:

We require confirmation at least **1 business day** prior to scheduled appointments to ensure we can honor your appointment. Confirmations can be made via response to our appointment communications through email, text, or phone call.
DO NOT CONFIRM and call us to reschedule if you are feeling ill. We understand that illness is uncontrollable, and we will work with you to reschedule you in a timely manner.

MISSED APPOINTMENTS:

If you are unable to keep your appointment, please contact our office **at least 48 hours in advance** so that we may accommodate other patients. We understand circumstances and emergencies do arise that are beyond control and we will work with you should this happen. Missed appointments for any reason other than emergencies will result in a fee of **$50.00** which will be required to be paid prior to being seen in the office again. Multiple failed appointments may result in dismissal from the clinic.

PATIENT SIGNATURE(S):

I have read this form and I understand it. All my questions have been answered.

TIME: _____ ⚪AM/⚪PM **DATE:** _____ **SIGNATURE:** _____

IF YOU ARE A PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN SIGNING FOR THE PATIENT:

PRINTED NAME OF PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN: _____

RELATIONSHIP TO PATIENT: _____

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TREATMENT CONSENT

NOTICE OF NONDISCRIMINATION:

West Michigan Foot and Ankle PLLC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. West Michigan Foot and Ankle PLLC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex or any other basis prohibited by law.

I AGREE:

- To examination and treatment by providers, residents, students, and other healthcare professionals at West Michigan Foot and Ankle PLLC. This may include in-person, telemedicine, videotaping, photographing and audio devices. These tools may be used to treat/diagnose or for procedures to be performed for medical, scientific and/or personal safety.
- That the provider may change my and/or my child's care to benefit my life or health.

I UNDERSTAND THAT:

- I will ask questions.
- No one has made promises or guarantees about the results of my treatment or care. I am aware the practice of medicine and surgery is not an exact science. No guarantees have been made to me as a result of my treatment or examination at West Michigan Foot and Ankle PLLC.
- Students and staff may see me and look at my medical record for teaching or research purposes.
- The staff will double-check who I am. They will ask what I am having done. This is to protect me.
- Michigan law allows healthcare providers to test my blood for HIV (AIDS virus) or Hepatitis without my consent if someone who has helped in my care is exposed to my blood or body fluids.
- West Michigan Foot and Ankle PLLC will not tolerate discrimination against my provider, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.
- Should my condition require referral to a specialist, I understand I will be asked my choice of a provider. I will have the opportunity to have West Michigan Foot and Ankle PLLC contact the provider of my choice or if I do not have a preference, an independent provider from West Michigan Foot and Ankle's "on-call" list will be called. I consent to my insurance company billing for professional services given by this provider whether or not this provider participates with my insurance program.
- This consent is valid for the entire duration of care at West Michigan Foot and Ankle PLLC. If there is a lapse in care spanning 3 years or more, a newly signed consent form will be required.

MY MEDICAL INFORMATION:

WEST MICHIGAN FOOT AND ANKLE MAY RELEASE MY MEDICAL INFORMATION TO:

- Insurance companies, health plans and administrators for payment of services I or my child receive(s).
- Government agencies like Medicare and Medicaid or as required by law.
- My providers and others involved in my care now or in the future.
- My employer, if the records are related to care or services paid for by my employer, or for other purposes that are allowed under law.
- Any person or entity responsible to pay all or part of my bill.

MY MEDICAL INFORMATION: (*continued)*

- I understand West Michigan Foot and Ankle PLLC will keep my or my child's medical information according to state law, federal law and policy. I also understand that my medical information may be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically.

- This includes my diagnosis, treatments, and medicine or prescription information. This may also include details about my mental health, infectious diseases, and other problems like drug or alcohol use disorder.
- In some cases, West Michigan Foot and Ankle PLLC is required by law to report medical information to an agency like the health department. This may include information about HIV, TB and other diseases.

PRIVACY NOTICE:

- I have rights and responsibilities when I or my child receive(s) services. West Michigan Foot and Ankle PLLC has made its Notice of Privacy Practices available, and I have had an opportunity to ask questions about the information in the Notice.

AUTHORIZATION TO RECEIVE PAYMENT AND BILLING:

- West Michigan Foot and Ankle PLLC is authorized to seek payment from any third party and from me. I authorize West Michigan Foot and Ankle PLLC to act on my behalf to collect benefits from any third party and endorse checks payable to me and/or West Michigan Foot and Ankle PLLC.
- I authorize any insurance company, responsible for payment of my medical care and treatment, to pay West Michigan Foot and Ankle PLLC for the services given. I understand that I am responsible for any charges not covered by insurance.
- I request payment due to me of authorized Medicare benefits be paid (on my behalf) to West Michigan Foot and Ankle PLLC for any services provided to me by West Michigan Foot and Ankle PLLC or in its facilities.
- I agree that if my account is not paid when due, the practice may retain a lawyer and/or collection agency for collection. I will be responsible to reimburse the practice for all costs, charges and fees associated with the collection of the amount due. This includes, but not limited to, reasonable interest, legal cost in the event a suit is filed and reasonable lawyer fees and/or reasonable collection agency fees including those based on a percentage of the debt.
- If you do not want us to bill your insurance, you must notify us at the time of service.

PATIENT SIGNATURE(S):

I have read this form and I understand it. All my questions have been answered.

TIME: _____ ⬜AM/⬜PM **DATE:** _____ **SIGNATURE:** _____

IF YOU ARE A PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN SIGNING FOR THE PATIENT:

⬜ PATIENT IS UNDER 18 YEARS OF AGE

⬜ PATIENT IS UNABLE TO CONSENT BECAUSE: _____

PRINTED NAME OF PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN: _____

RELATIONSHIP TO PATIENT: _____

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PAD Patient Intake Questionnaire

Answers to the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD_ and if a vascular examination can help better assess your vascular health status.

1	Do you experience any pain in your legs or feet while at rest?	⬜ Yes ⬜ No
2	Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise?	⬜ Yes ⬜ No
3	If yes to Question 2, does the pain go away when you stop walking/ exercising?	⬜ Yes ⬜ No
4	Do your feet get pale, discolored or bluish at any time during the day?	⬜ Yes ⬜ No
5	Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	⬜ Yes ⬜ No
6	Are you over the age of 65	⬜ Yes ⬜ No
7	Are you over the age of 50	⬜ Yes ⬜ No
8	Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	⬜ Yes ⬜ No
9	Do you have high blood pressure or take medication to reduce blood pressure?	⬜ Yes ⬜ No
10	Do you have diabetes?	⬜ Yes ⬜ No
11	Do you have a history of chronic kidney disease?	⬜ Yes ⬜ No
12	Do you currently or have you ever smoked?	⬜ Yes ⬜ No
13	Do you have a history of stroke or mini-stroke (TIA)?	⬜ Yes ⬜ No
14	Do you have a history of heart disease (heart attack, MI)?	⬜ Yes ⬜ No
15	Do you have a history of carotid stenosis, AA (abdominal aortic aneurysm), and/ or stent placement?	⬜ Yes ⬜ No