Westland Foot & Ankle Specialists, P.C. - New Patient Form **Please Print**

Last Name:_____ First Name:_____ MI:_____

Address: _____ City: _____ State:_____ Zip:_____

Home # ( ) _____ Cell # ( ) _____ Work # ( ) _____

Emergency Contact:_____ Phone: ( ) _____ Relationship: _____

E-Mail: _____ Birth Date: ____/____/____

Race: _____ Language:_____ Hispanic☐ Non-Hispanic☐

Family Physician: _____ Phone Number: ( ) _____

Fax Number: ( ) _____

Social Security Number:_____ Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Employer: _____ Employer Address: _____

Pharmacy: _____ Pharmacy Phone Number: ( ) _____

HOW DID YOU HEAR ABOUT US: **Doctor Referral** ☐ **Insurance** ☐ **Friend/Family** ☐ **Internet/Google** ☐

Referred by:_____ Other:_____

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorized medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in care and with those listed below.

Name Phone Number Relationship

_____

_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____ to pay and hereby assign directly to Westland Foot & Ankle Specialists, P.C. all benefits. I further acknowledge that any insurance benefits, when received by and paid to Westland Foot & Ankle Specialists, P.C. will be credited to my account in accordance with the above said assignment.

Agreed & Authorized: _____ **Date**: _____

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Last Name:_____ First Name:_____

MEDICAL HISTORY:

Previous Surgery/Hospitalizations_____

_____

Injuries and Fractures (types & dates):_____

FAMILY HISTORY (check if anyone in your family has had or had the following)

	MOTHER	FATHER	SILBINGS	CHILDREN	OTHER RELATIVE
CANCER					
DIABETES					
HEART DISEASE					
ARTHRITIS					
OSTEOPOROSIS					
AGE (IF LIVING)					

SYSTEMIC REVIEW (DO YOU NOW HAVE OR EVER HAD THE FOLLOWING)

	YES	NO		YES	NO
Chronic Headaches/Migraines			**Multiple Sclerosis**		
Dizziness			**Swelling of ____Feet _____Ankles**		
Fainting Spells/Blackouts			**Numbness/Tingling of hand/Feet**		
Eye Disease/Glaucoma/Cataracts			**Color Changes in the Hands/Feet**		
Double Vision			**Chest Pressure/Chest Pain**		
Recent Vision Impairment			**Chronic Back Pain**		
Impaired Hearing			**Chronic Neck Pain**		
Ringing in the Ears			**Parkinson's Disease**		
Dryness of _____Eyes _____Mouth			**Osteoporosis**		
Recent Hair Loss			**Sciatica**		
Asthma			**Anemia or Blood Disorder**		
Recurrent Fever			**Skin Rash**		
Thyroid Disorder Hypo_____ Hyper____			**Psoriasis**		
Pneumonia			**Recent Weight ____Gain _____ Loss**		
Pleurisy			**Loss of Appetite**		
Frequent Cough			**Constant Thirst or Hunger**		
Tuberculosis Exposure			**Stomach/Duodenal Ulcer**		
Difficulty Breathing			**Abdominal Pain/Heart Burn**		
Rheumatic Fever			**Frequent Nausea/Vomiting**		
Rheumatoid Arthritis			**Heart Murmur**		
Osteoarthritis			**Cancer (if yes, Type and Treatment)_____**		
Prostate Disorder			**Palpitations**		
Recurring Bladder Infections			**Convulsions OR Epilepsy**		
Kidney Disease/Stones			**Hepatitis/Jaundice**		
Phlebitis			**HIV Virus Positive**		
Insomnia			**Chronic Anxiety**		
Diabetes Age Diagnosed_____			**Depression**		
High Blood Pressure					
High Cholesterol					

Most Recent Medical Exam:_____ Shoe Size:_____

Reason for office visit today: _____

SOCIAL HISTORY

Do or Did you smoke cigarettes? ☐Yes ☐No If Yes, packs per day?_____Stop date: _____

Drink alcohol regularly? ☐Yes ☐No Do you exercise regularly? ☐Yes ☐No

Recreational drug use? ☐Yes ☐No

Coffee use? ☐Yes ☐No

TB test? ☐Yes ☐No

Allergies to any medication? ☐Yes ☐No If Yes, which medications? _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING ON THE BACK:

_____