Freeland Foot and Ankle Clinic
7305 Midland Rd Ste 2
Freeland, MI 48623
(989) 695-6788

Freeland Foot and Ankle Clinic Mission Statement

At Freeland Foot and Ankle Clinic we are committed to getting you back on your feet free of pain and injury so that you can get back to your activities and back into life! We understand that when your feet hurt you hurt all over and you stop doing the things you love to do. We stop the pain and prevent the injuries that occur in people's feet, ankles, legs, knees, hips and backs by addressing the imbalances which most often begin in the feet! We feel your feet are your foundation and a strong foundation is our goal. We thank you for the opportunity to serve you and give you the results you are looking for.

Sincerely,
Dr. Timothy Dailey

Mr. Dr. Today's Date: _____
Mrs. _____
Miss. Last Name First Name MI. Age: _____ Birthday: _____

Local Address: _____ Home Phone #: (_____) _____

City: _____ State: _____ Zip: _____ Cell Phone #: (_____) _____

Social Security #: _____ Sex: M / F Marital Status: S M W D E-mail address _____

I live here _____ months of the year, usually from _____ to _____ or Just Visiting

Other Address (if any): _____ Phone: (_____) _____

Occupation: _____ If retired, your former occupation: _____

Patient's Employer: _____ Business Phone: (_____) _____

Spouse: _____ Are they our patient? Yes / No

Are any of your friends, relatives or associates our patient? Yes / No If Yes, who? _____

If under 18 y/o, name of parent/guardian: _____ Relationship to Patient: _____

Responsable parties DOB: _____- _____ - _____ Responsable parties SS#: _____ - _____ - _____

Whom may we thank for your referral? _____

How did you here about our practice? _____

If you used the internet to find us what search terms were used? _____

Emergency Notification

In case of emergency, notify: _____ Relationship: _____

Home Phone: (_____) _____ Business Phone: (_____) _____ Other: (_____) _____

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Patient Name: _____

Primary Physician: _____ Last visit: _____ - _____

Former Podiatrist Name: _____ Last visit: _____ - _____

Other Physician: _____ Last visit: _____ - _____

Medical History

1. How is your general health? Good Fair Poor
2. Are you now, or within the past two years, under a physician's care? Yes No
   If yes, what are you being treated for: _____
   _____
3. Do you take prescribed and/or over the counter medicine? Yes No
   If yes, what medications are you taking? (Please list or provide a copy of list): _____
   _____
   _____
4. Are you allergic to any medicines, adhesive tape, latex or penicillin? Yes No
   (Please list All allergies you have)**:** _____
   _____
5. Do you have now, or have you ever had any of the following:

Diabetes	Liver Problems	Growing Pains
Kidney Trouble	Hepatitis	Arthritis
Heart Trouble	HIV / ARC	Scoliosis
High Blood Pressure	Cancer	Foot Ulcers
Anemia	Skin Cancer	Phlebitis
Asthma	Melanoma	Numbness in feet or legs
Blood Diseases	Gout	Cramps in feet or legs
Rheumatic Fever	Circulation Disease	Broken Bones in Leg
Reynaud's Disease	Stomach Ulcers	Broken Bones in Feet
Thyroid Condition	Eye Problems	Other _____

6. Is there a family history of Diabetes? Yes No Insulin Dependant? Yes No
7. Have you had any surgeries? Yes No [If yes, **Please list below:]**

Date (recent first)	**Surgical Procedures and / or Traumatic Injuries**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Patient Name: _____

1. **Do you have any FOOT pain?** Yes No Right Left Both
   If yes, Please explain: _____
   _____
   For how long? _____
   Previous treatment for this pain / problem? Yes No
   If yes, Please explain: _____
   _____
   Does anything make it better or worse? _____
   _____

2. **Do you have any KNEE pain?** Yes No Right Left Both
   If yes, Please explain: _____
   _____
   For how long? _____
   Previous treatment for this problem? _____ Yes No
   Please explain: _____
   _____
   Does anything make it better or worse? _____
   _____

3. **Do you have any HIP pain?** Yes No Right Left Both
   If yes, Please explain: _____
   _____
   For how long? _____
   Previous treatment for this problem? _____ Yes No
   If yes, Please explain: _____
   _____
   Does anything make it better or worse? _____
   _____

4. **Do you have any Back pain?** Yes No Upper Back Lower Back Neck
   If yes, Please explain: _____
   _____
   For how long? _____
   Previous treatment for this problem? _____ Yes No
   If yes, Please explain: _____
   _____
   Does anything make it better or worse? _____
   _____

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Patient Name: _____

5. Do you have any leg cramps or pain? Yes No / Right Left Both

If yes, Please explain: (include Frequency)_____

_____

_____

How long has this been going on? _____

Previous treatment for this problem?_____ Yes No

If yes, Please explain: _____

_____

Does anything make it better or worse?_____

_____

6. Do any of the above problems limit your ability

to walk? Yes No _____

_____

to stand? Yes No _____

_____

to wear shoes? Yes No _____

_____

to work? Yes No _____

_____

to partake in social or sporting activities? Yes No _____

7. Do you currently wear or have you ever worn Orthotics (arch supports)? Yes No

If yes, were they prescribed to you by a physician or health care provider Yes No

If yes, were they the over the counter style bought from a store Yes No

If yes, did you find that they helped you to any significant degree Yes No

8. If you are a runner or athlete please tell us about your sport. Include recent history, weekly mileage breakdown, frequency or times and if you are currently training for any event.

_____

_____

_____

9. What type of Shoes do you wear and how often do you wear them? Please Circle or cross out

MALE		**FEMALE**	
Sneakers / Tennis Shoes	_____ % of time	Sneakers / Tennis Shoes	_____ % of time
Lace Up Dress Shoes	_____ % of time	Casual Shoes	_____ % of time
Loafers or Deck Shoes	_____ % of time	Pumps or Low Heel Open Shoes	_____ % of time
Work Boots or Other Boots	_____ % of time	High Heel Shoes (2 inch or greater)	_____ % of time
Flip Flops or Sandals	_____ % of time	Work Boots or Other Boots	_____ % of time
		Flip Flops or Sandals	_____ % of time

10. When you're at home, what is on your feet?

Regular Shoes _____ % of time Slippers _____ % of time Bare Feet _____ % of time

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Patient Name: _____

This is the most important part of this paper work.

11. In the last few months has there been a recent change in your:

Weight Work Activity Shoe Gear Flooring at work or home

Please explain: _____

_____

Please tell us what are your Goals and Expectations are relating to your problem:

Relating to your specific complaint(s), what would you like to accomplish **during your visit today?** _____

_____

_____

_____

Relating to your specific complaint(s), what would you like to be able to accomplish **in the near future** that you may not be able to do right at this moment? **(Please include intermediate and long term goals)** _____

_____

_____

_____

I understand that any follow-up appointments I make are crucial to my treatment and the success of my care. During these appointments, the Doctor will give you the necessary attention. Please have the courtesy of keeping all appointments or calling to change an appointment with 24 hours notice.

I understand that I will be charged a fee of $35.00, for any appointments missed with less then 24 hours cancellation notice.

Patient/ Guardian Print: _____ Date: _____

Patient/ Guardian Signature:_____ Date: _____

Thank you very much for filling out our New Patient paper work. Please return the forms to the receptionist when you come in along with your insurance card (if applicable) and your photo ID.

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Insurance Information / Consent / Authorization

Please bring your insurance cards and a photo ID to the front desk so we may make photocopies.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediary or carriers, or to the billing agent of Freeland foot and Ankle Clinic, any information needed for this claim. I permit a copy of this authorization to be used in place of the original. I authorize the release of my medical records to and /or from my physician or other health care providers.

I understand that payment is due at the time of service unless other arrangements have been made I also understand that when payment becomes my responsibility after 60 days, I may be charged an interest rate of 18% or 1.5% of the outstanding balance.

Patient / Guardian Print: _____ Date: _____

Patient / Guardian Signature: _____ Date: _____

Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to: Freeland Foot and Ankle Clinic for any service furnished me by the physician.

Patient / Responsible Party Print: _____ Date: _____

Patient / Responsible Party Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the Notice of Privacy Practices and that I have read, had the opportunity to read, or plan to take it home to review. It is my understanding that if I have a question, I may contact the privacy officer at Freeland Foot and Ankle Clinic.

_____ _____
Patient Name (please print) Date

_____
Parent or Guardian (if applicable) (please print)

_____
Signature