7305 Midland Rd Suite #2
Freeland, MI 48623

www.FreelandFoot.com
Ph: (989)695-6788 Fax: (989)695-6491

Our Mission Statement

At Freeland Foot and Ankle Clinic we are committed to getting you on your feet, 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 provide the best conservative foot care with the most up to date technologies to stop the pain and prevent the injuries which most often begin in the feet! 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: _____ Date of Birth: ______________

Address: ____ Home Phone #: (_____) ___________

City: ______________________ State: ____________ Zip: _____________ Cell Phone #: (_____) ___________

Sex: M F Marital Status: E-mail address ______________________________

Occupation: ____________________________ If retired, your former occupation: ___________________________

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

Spouse: ____ Are they our patient? No Yes

If under 18 y/o, name of parent/guardian: ____

Relationship to Patient: _____________________________Responsible parties DOB: ______- ______ - __________

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

Whom may we thank for your referral? ____

How did you hear 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: (_____) ____________

Primary Physician: ____ Last visit: ________________

Former Podiatrist Name: ____ Last visit: ________________

Other Physician: ____ Last visit: ________________

PHARMACY: ____

Reason for visit:____

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 **<u>during your visit today</u>?**

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

Medical History

Height:_____________ Weight:_____________ Shoe Size:__________________

1. How is your general health? Good _ Fair Poor

2. Do you take prescribed and/or over the counter medicine? No Yes

If yes, what medications are you taking? (Please list or provide a copy of list):

3. Are you allergic to any medicines, adhesive tape, latex or penicillin? No Yes

(Please list All allergies you have)**:**

4. 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 ____________________

If you are diabetic please provide additional detail. Do you use insulin? No Yes

Did you check your blood sugar today? No Yes, what was it? ______________________

When was your most recent A1C?_____________ What was it?__ _______________________

Physician who follows your Diabetic care:________________ Date you were last seen?_______

5. **Have you had any surgeries?** No Yes **If yes, Please list below with approximate date:**

6. **Do you have any FOOT or ANKLE pain?** No Yes Right Left Both
   If yes, please explain:

7. **For how long?**

8. **Previous treatment for this pain / problem?** No Yes
   If yes, please explain:

9. **What makes it better?**

10. **What makes it worse?**

11. **Do you have any KNEE pain?** No Yes Right Left Both
    If yes, please explain:

8. **Do you have any HIP pain?** No Yes Right Left Both
   If yes, please explain:

9. **Do you have any Back pain?** No Yes Upper Back Lower Back Neck
   If yes, please explain:

10. **Do any of the above problems limit your ability to**

Walk? No Yes **Stand?** No Yes **Wear shoes?** No Yes
Work? No Yes **Partake in social or sporting activities?** No Yes

11. **Do you currently wear or have you ever worn Orthotics (arch supports)?** No Yes
If yes, were they prescribed to you by a physician or health care provider No Yes
If yes, were they the over the counter style bought from a store No Yes
If yes, did you find that they helped you to any significant degree No Yes

12. **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.**

13. **What type of Shoes do you wear and how often do you wear them?**

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 Shoes	% of time	Work Boots or Other Boots	% of time
Flip Flops or Sandals	% of time	High Heel Shoes (2 inch or greater)	% of time

14. **When you're at home, what is on your feet?**
    Shoes _______ % of time Slippers _______ % of time Bare Feet _______ % of time

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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 initial: __________

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 / Guardian initial: __________

Office Cancellation / No Show Policy

Please have the courtesy of keeping all appointments or calling to change an appointment with 24 hour notice. **I understand that I will be charged a fee of $30.00, for any appointment missed without notice of cancellation.**

Patient / Guardian initial: __________

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 / Guardian initial: __________

I consent to receive appointment reminders and practice updates using the contact information provided above.

Automated text message: Yes No Email: Yes No

________________________________ Patient Name (please print

________________________________ Date

________________________________ Parent or Guardian Name (if applicable

________________________________ Signature