ARBOR-YPSI FOOT & ANKLE CENTERS
Dr. Bradley E. Seel, D.P.M.
Diplomate, American Board of Podiatric Surgery
Certified in Foot Surgery
3768 Packard • Suite A • Ann Arbor, MI 48108 • 734/975-1700 • fax 734/975-1711

Patient Fact Sheet

This information is strictly confidential

Today's Date: _____

Name: _____Date of Birth: _____
(Last) (First) (Middle)

☐Male ☐Female SS#: _____

If patient is a minor, name of responsible adult: _____

Home Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

☐Single ☐Married ☐Widow(er) ☐Partner ☐Divorced

Spouse: _____Date of Birth: _____
(Last) (First) (Middle)

Spouse Primary Phone: _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Pharmacy: _____
(Name) (Location)

How did you hear about our office? _____

ALL CHARGES FOR SERVICES ARE THE RESPONSIBILITY OF THE PATIENT

Due to the many changes in insurance policies; it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the policyholder, to please check with your insurance company prior to any treatment or surgery. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

A **$35 fee** will be charged for cancelled or missed appointments without twenty-four hour advance notice. Should the account be referred to a collection agency, the patient shall pay collection expense and attorney's fees if applicable.

Language: _____ Race: _____ Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Patient signature: _____ Date: _____
(Signature of Parent or Legal Guardian if patient is a minor or incompetent to give consent)

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Patient Medical History

Today's Date: _____

Patient Name: _____ **Date of Birth**: _____
Height: _____ Weight: _____ Shoe Size: _____ Age: _____

What is your foot/ankle problem?

_____

When did you first notice the problem?

_____

Have you ever been treated for this? (When/Where)

_____

Are you diabetic? _____ If yes, controlled by: □Diet □Insulin □Medication:_____
Please list medications and dosage: _____
_____

Allergies and Reaction: (Please check all that apply)
□Aspirin □Bactrim □Codeine □Iodine □Novocain □Demerol
□Penicillin □Sulfa □Adhesive Tape □Latex □Antihistamines □Food □Other: _____

Medical history: (Please check all that apply)

□Anemia	□Arteriosclerosis	□Arthritis	□Asthma	□Bleeding Tendencies
□Cancer	□COPD	□Diabetes	□Epilepsy	□Eye Problems
□Gout	□Heart disease	□Hepatitis	□High Blood Pressure	□High Cholesterol
□HIV/AIDS	□Kidney disease	□Numbness	□Polio	□Rheumatic Fever
□Scarlet fever	□Heart Stent	□Stomach Ulcers	□Stroke	□Tuberculosis
□Tumors	□TBI	□Currently Pregnant	□Currently Breastfeeding	□GERD

Surgical History: _____
_____

Do you smoke? □No □Yes ___pack/day x ___ years. Quit, but I smoked ___ pack/day x years.
Do you drink alcohol? □No □Yes How often? _____ Recreational Drugs? □Yes □No

Is there anything else we should know? _____

I hereby give authorize Bradley E. Seel D.P.M., P.C. to examine, perform diagnostic tests, and treat my feet medically, surgically, and or orthopedically. I also authorize the release of any medical information necessary to process this claim. All benefits are to be paid to the above named physician for any services rendered.

Patient signature: _____ Date: _____
(Signature of Parent or Legal Guardian if patient is a minor or incompetent to give consent)

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Today's Date: _____

Patient Name: _____ **Date of Birth**: _____

Personal History: (Please check all that apply)

	Yes	No
Bunion/HAV		
Thick Nails		
Dizziness		
Peripheral Vascular Disease		
Swelling of Feet		
Extremities Cold		
Stroke or CVA		
Varicose Veins		
Persistent Cough		
Tuberculosis		
Shortness of Breath		
Athletes Foot		
Deformed Nails		
Ingrown Nail		
Wart		
Corns/Calluses		
Skin Cancer		

	Yes	No
Ankle Pain		
Broken Bones		
Hammer Toes		
Joint Stiffness		
Muscle Pain/Weakness		
Painful Toe(s)		
Arthritis		
Bursitis		
Foot Pain		
Heel Pain		
Low Back Pain		
Numbness		
Dementia		
Anemia		
Bleeding Disorder		
Anxiety		
Depression		

Date of Last Mammogram: _____ Date of Last Influenza Vaccine: _____

Date of Last Colonoscopy: _____ Date of Last Pneumonia Vaccine: _____

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Today's Date: _____

Patient Name: _____ **Date of Birth**: _____

Family Medical History: (Please provide medical history for your mother **OR** father)

□ Adopted □ Unknown

Name: _____

Date of Birth: _____ Approximate Age: _____

Living: □ Yes □ No If no, cause of death: _____

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino

Race: □ American Indian or Alaska Native
□ Asian
□ Black or African American
□ White
□ Other: _____

Smoking Status:
□ Current
□ Former
□ Never
□ Unknown

Language: _____

Family History of:
□ Diabetes
□ Cancer
□ Heart Disease
□ Hypertension
□ Other: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____ _____

Patient Name Date of Birth Today's Date

_____

Parent of Authorized Representative (if applicable)

_____

Signature

Notices of Privacy Practices is located behind this page. Copies are available at the desk.