RYAN FOOT AND ANKLE CLINIC, P.C.
LAWRENCE BROWN, D.P.M., D.A.B.P.S.

BOARD CERTIFIED, AMERICAN BOARD OF PODIATRIC SURGERY
BOARD CERTIFIED, AMERICAN BOARD OF PODIATRIC ORTHOPEDICS AND PRIMARY PODIATRIC MEDICINE
FELLOW, AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS
FELLOW, AMERICAN COLLEGE OF FOOT AND ANKLE ORTHOPEDICS MEDICINE

25511 VAN DYKE, SUITE 100
CENTER LINE, MI 48015
TELEPHONE: (586) 758-5770
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WE ARE PLEASED TO HAVE YOU WITH US

We wish to welcome you to our office. Please answer these questions to help us become better acquainted. If you need any help, please don't hesitate to ask.

NAME____________________ **DATE OF BIRTH**________ **AGE**_____

ADDRESS:____________________ **CITY**__________ **ZIP**______

HOME #____________ **WORK #**____________ **ALT #**________

SOCIAL SECURITY#____________ **MARITAL STATUS**________ **SEX**_____

EMAIL ADDRESS________________________

EMPLOYER____________________ **OCCUPATION**____________

INSURANCE COMPANY________________ **POLICY HOLDER**__________

POLICY HOLDER NAME AND DATE OF BIRTH____________________

HOW DID YOU FIND OUT ABOUT OUR OFFICE____________________

EMERGENCY CONTACT NAME AND NUMBER____________________

I hearby give permission to Dr. Lawrence Brown or Dr. Steven Magier to administer treatment and to perform such minor operative procedures as deemed necessary in the diagnosis and/or treatment of my foot or ankle condition.

I request that payment of authorized insurance benefits be made on my behalf to:
Ryan Foot & Ankle Clinic, P.C./ Dr. Lawrence Brown/ Dr. Steven Magier for any services furnished me by that physician/clinic/supplier. I authorize this clinic to release any information pertinent to my case to my insurance company (companies).

I agree to be financially rsponsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company. I understand that it is my responsibility to know my insurance plan and all applicable limitations/restrictions and/or copays and deductible for which I may be charged.

A photocopy of this assignment shall be considered as effective and valid as the original.

PATIENTS SIGNATURE________________________ DATE__________

PATIENT'S NAME_______________

MEDICAL INFORMATION

This Information is Important For Our Records And Your Health

Describe your foot problem _______________

____

____

____

How long has it been bothering you?______Days______Weeks______Years

Any past problems of your feet and ankles? _______________

____

____

Any past surgical procedures on your feet or ankles? _______________

____

____

Shoe size_______________Current Weight_______________Height_______________

Are you allergic or sensitive to:

Antibiotics (Penicillin, Sulfa, drugs, etc.?) _______________

Any medicines _______________

Tape?_____________ Betadine (Iodine)?___________ Other_______________

Have you had problems taking aspirin or Ibuprofen (Advil, Motrin)?_______________

Yes__________No__________

Any problem with local anesthetics(Novocaine, Lidocaine)? Yes_______ No_______

Are you allergic to insect bites/bee stings? Yes___ No___

GENERAL HEALTH INFORMATION

Do you have Diabetes? Yes____No____ If yes, do you take insulin? Yes____No____

Number of Years_______________

Have you had any serious illnesses? _______________

Have you had any major surgeries? _______________

Are you under a physician's care? Yes_____ No_____If yes, for what condition

____

Family Physician_______________ Date you last saw this Doctor_______________

~~DOCTOR'S PHONE#~~

May we contact your physician about your health? Yes_____ No_____

Name of your Pharmacy or Drug Store_______________ Phone#_______________

What medications do you take regularly? _______________

____

____

OVER

Check ☐ any of the following you have, or have had a problem with:

☐ Heart	☐ Asthma	☐ Skin	☐ Unexplained weight loss
☐ Circulation	☐ Stomach Ulcers	☐ Gout	☐ Frequent Infections
☐ Arthritis	☐ Hormones	☐ Tuberculosis	☐ Healing
☐ Kidneys	☐ Anemia	☐ Rheumatic Fever	☐ Neurological Disorder
☐ Lungs	☐ Bladder	☐ Liver	☐ Intestines
☐ Cancer	☐ High Blood Pressure		

Do you have any artificial joints?

Hip Yes _____ No _____

Knee Yes _____ No _____

Other _________________

Do you have Heart Valve Implant? Yes _____ NO _____

Family History

Mother	Living _________	Deceased _________	Cause of Death ____________
Father	Living _________	Deceased _________	Cause of Death ____________
Brother	Living _________	Deceased _________	Cause of Death ____________
Sister	Living _________	Deceased _________	Cause of Death ____________

Is there a family (blood relative) history of:

☐ Heart Disease
☐ Arthritis
☐ Bleeding Disorder
☐ Neurological Disorder
☐ Stroke
☐ Bunions
☐ Hammertoes
☐ Flatfeet
☐ Circulation problems in legs or feet

Do you smoke? Yes __________ # packs per day ______________ No __________

Previously smoked? Yes________ # of years __________ No _______

Do you drink alcohol or beer? Yes __________ No __________

☐ Light Usage 1 -2 per week ☐ Moderate, 1 - 2 per day ☐ Heavy, more than 2 per day

Employment: ☐ Sits at job ☐ Stands at job ☐ Stands & Walks at job ☐ Retired

Signature ____________________________________ Date ______________________