MICHIGAN FOOT & ANKLE CENTER

1515 Lake Lansing Road, Ste. B-1
Lansing, MI 48912
(517)487-5171
cesarfootcare.com

Please provide the following information for our records and be prepared to show all insurance cards to our receptionist.

PATIENT'S NAME ______________________ ______________________ ______________________
(LAST) (FIRST) (MIDDLE)

DATE OF BIRTH: ____________ **SEX:** F ☐ M ☐ **SOCIAL SECURITY NO:** ______________________

MARITAL STATUS: S ☐ M ☐ D ☐ W ☐ **NAME OF SPOUSE:** ______________________

STREET ADDRESS: ____

CITY: ______________________ **STATE:** ______ **ZIP CODE:** __________

HOME PHONE #: ______________________ **CELL PHONE #:** ______________________

☐ *Please check if **health related messages** are allowed.* ☐ *Please check if **health related messages** are allowed.*

EMPLOYER: ______________________ **OCCUPATION:** ______________________

WORK PHONE #: ______________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY (OTHER THAN SPOUSE)

NAME: ______________________ RELATION: __________ PHONE #: ______________

How did you hear about our office? ____

PLEASE CHECK ALL THAT APPLY:

ETHNICITY

☐ Hispanic or Latino
☐ Not Hispanic or Latino
OTHER: __________

RACE

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaskan Native
OTHER: __________

PREFERRED LANGUAGE

☐ English
☐ Spanish
OTHER: __________

IS THIS INJURY / ILLNESS RELATED TO AN AUTO ACCIDENT, WORK ACCIDENT, OR OTHER ACCIDENT? ☐ YES ☐ NO

IF APPLICABLE, HAS WORKER'S COMPENSATION BEEN FILED? ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________ SECONDARYINSURANCE______________________

CARD HOLDER'S NAME ______________________ CARD HOLDER'S NAME ______________________

CARD HOLDER'S DATE OF BIRTH ______________________ CARD HOLDER'S DATE OF BIRTH ______________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM TO GARY L. CESAR, D.P.M., P.C., AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO HIM FOR SERVICES RENDERED, WHEN HE REQUESTS THOSE PAYMENTS BE MADE DIRECTLY TO HIM.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES THAT HAVE BEEN RENDERED TO ME. I UNDERSTAND THAT GARY L. CESAR, D.P.M., P.C. WILL BILL MY INSURANCE BUT THAT I AM RESPONSIBLE FOR ANY BALANCE THAT MY INSURANCE DOES NOT PAY AND ANY COPAYMENTS AND/OR DEDUCTIBLES.

SIGNATURE: ______________________________________ DATE: ______________

MICHIGAN FOOT & ANKLE CENTER

PERSONAL HEALTH HISTORY

TODAY'S DATE: ______________________ **DATE OF YOUR BIRTH:** ______________________

PATIENT NAME: ______________________________________ **AGE:** ______________

FAMILY PHYSICIAN: ______________________________________ **CITY:** ______________

PATIENT HISTORY

HEIGHT: ______________ **WEIGHT:** ______________ **SHOE SIZE:** ______________

PLEASE EXPLAIN YOUR CURRENT FOOT PROBLEM AND THE DURATION OF THE PROBLEM: ______________

____

____

WHAT TREATMENT OPTIONS HAVE YOU TRIED TO HELP WITH YOUR CURRENT FOOT PROBLEM? (Check all that apply)

- ☐ Altered Activity
- ☐ Topical Medications
- ☐ Physical Therapy
- ☐ Altered Shoe Wear
- ☐ Injections
- ☐ X-Rays
- ☐ Shoe Inserts
- ☐ NSAID's
- ☐ Surgery

PLEASE LIST ALL MEDICATIONS (INCLUDING VITAMINS & HERBAL SUPPLEMENTS): ______________

____

____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS: ______________________________

____

____

PLEASE LIST ANY PAST SURGICAL HISTORY: ______________________________

____

____

SOCIAL HEALTH HISTORY

Use of Alcohol: ☐ Yes ☐ No ______ Drinks/Day ______ Drinks/Week ______ Drinks/Month

Use of Tobacco: ☐ Yes ☐ No ______ Packs/Day ______ Packs/Week

Use of Recreational Drugs: ☐ Yes ☐ No Type/Frequency ______________________

Initials & Date: ____________ Initials & Date: ____________ Initials & Date: ____________ Initials & Date: ____________

PERSONAL HEALTH HISTORY

Please check either yes or no	No	Yes, Now	Yes, Past	Please check either yes or no	No	Yes, Now	Yes, Past
Diabetes – Insulin Dependent				Heart Disease			
Diabetes – Non Insulin Dependent				Congestive Heart Failure			
Bleeding Disorder				Asthma			
Numbness				Coldness			
Epilepsy				Bronchitis			
Pneumonia				Scarlet Fever			
Dyspnea				Rheumatic Fever			
Hepatitis ☐ A ☐ B ☐ C				Sexually Transmitted Infection			
HIV/AIDS				Anemia			
Hypertension				Kidney			
Stroke				Gout			
Cramps				Thyroid			
Arthritis				Stomach Problems			
Emphysema				Ulcers			
Urinary Tract Infection				Tuberculosis			
Cancer				Pregnancy			
Glaucoma				Liver Disease			
Phlebitis or Blood Clots				Skin Disease/Psoriasis/Eczema			
☐ Weight Loss ☐ Weight Gain				Parkinson's Disease			

OTHER:____

ANY BLOOD DISEASES/DISORDERS:______________________________

Initials & Date: _____________ Initials & Date: _____________ Initials & Date: _____________ Initials & Date: _____________

FAMILY HEALTH HISTORY PART 1

Please check either Yes or No. If yes, please indicate the family member who has or has had any of the medical problems listed.	YES	NO	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER	GRANDPARENT
Diabetes									
Bleeding Disorder									
Numbness									
Epilepsy									
Pneumonia									
Dyspnea									
Hepatitis ☐ A ☐ B ☐ C									
Hypertension									
Stroke									
Cramps									
Arthritis									
Emphysema									
Urinary Tract Infection									
Cancer									

OTHER:____

Initials & Date: ______________ Initials & Date: ______________ Initials & Date: ______________ Initials & Date: ______________

FAMILY HEALTH HISTORY PART 2

Please check either Yes or No. If yes, please indicate the family member who has or has had any of the medical problems listed.	YES	NO	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER	GRANDPARENT
Heart Disease									
Asthma									
Coldness									
Bronchitis									
Scarlet Fever									
Rheumatic Fever									
Sexually Transmitted Infection									
Anemia									
Kidney									
Gout									
Thyroid									
Stomach Problems or Ulcers									
Tuberculosis									
Phlebitis or Blood Clots									

OTHER:____

Initials & Date: ______________ Initials & Date: ______________ Initials & Date: ______________ Initials & Date: ______________