THE FOOT CARE INSTITUTE OF MICHIGAN

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The "Health Insurance Portability and Accountability Act" (*HIPPA*) gives individuals the right to request a restriction on use and disclosure of "Personal Health Information" (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as correspondence to the individuals works instead of home.

The Privacy Rule generally requires Healthcare providers to take steps to limit their use and disclosure of your PHI.

Note: Use and Disclosure for emergencies may be permitted without prior consent

I wish to be contacted in the following manner: (please check all that apply)

- ☐ **Home Phone:**_____
- ☐ **Cell Phone:**_____
- ☐ **Work phone:**_____
- ☐ **Other Phone:**_____
- ☐ **Okay to leave basic messages with callback number only**
- ☐ **Okay to leave detailed messages with specific information**

Written & Electronic Communications:

- ☐ **Okay to mail information to my home address** (see patient information form for address)
- ☐ **E-Mail:**_____

The following individuals may have access to my "Personal Health Information"(PHI)

Name	Relationship	Phone Number

ACKNOWLEDGEMNT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing my name below, I acknowledge that I received a copy of this office's "NOTICE OF PRIVACY PRACTICES" outlining how my confidential PHI will be used, disclosed and protected.

X_____ _____

Patient Signature **Date**

Charles Young, D.P.M., FACFAS
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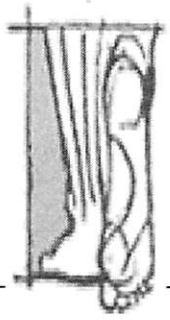

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OF MICHIGAN

PATIENT AUTHORIZATUION FOR PAYMENT

Patient Name: _____ Date: _____

Payment is subject to the terms of your insurance policy and can only be determines at that time the claims are processed. If for any reason your insurance carrier denies your claim, you accept responsibility to pay the entire balance or any remaining balance.

Verification of eligibility and benefits is the responsibility of you, the patient.

PATIENT SIGNATURE: _____ DATE: _____

11885 East Twelve Mile Road • Ste. 202 • Warren, MI 48093 • (586) 755-4242
21111 Middlebelt Road • Farmington Hills, MI 48336 • (248) 478-1150
11650 Belleville Rd. Ste. 105 • Belleville MI 48111 • (734) 699-2400

THE FOOT CARE INSTITUTE OF MICHIGAN

Please Print

PATIENT INFORMATION

Name:

_____

Last First Middle Initial

Mailing
Address:_____

City:_____ State:_____

ZIP:_____

Phone#_____

2ndNo._____3rdNo._____

DOB:_____ Gender: Male Female SSN:_____

Marital Status: S M W D If insurance is in spouse's or parent's name, what is their

Name: _____

DOB: _____

Phone#:_____

Email
Address:_____

I hereby give my permission to the doctors to administer such procedures as may be deemed necessary in the diagnosis and treatment of my foot condition. Furthermore, I acknowledge that I am fully responsible for all deductibles or portions of medical expenses not covered by my insurance company.

Date_____Signature_____Relationship_____

Medical History

Height_____ Weight_____ Shoe Size_____ Age_____

Please describe your foot problem(s) _____

_____

Have you been under the care of a medical doctor in the past two years? YES_____ NO_____

If so, why?_____

_____

Primary physician's name_____Phone number_____

Allergies:_____

_____

Do/Did you smoke? Y_____ N_____ Drink alcohol: Y_____ N_____ How often?_____

Recreational drug use? Y_____ N_____ Do you bruise or bleed easily? Y_____ N_____

WOMEN: Are you currently pregnant? Y_____ N_____

List all previous surgeries and complications:_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or medications I will inform the doctor at my next appointment.

Date_____ Name (please print) _____

Signature_____

PLEASE CHECK ALL THAT APPLY W/ S FOR SELF OR F FOR FAMILY

ENT/EYES

_____ Carnea Abrasion
_____ Dry eye
_____ Deviated Septum
_____ Glaucoma

CARDIOVASCULAR

_____ Arrhythmia
_____ Blood Pressure Abnormality
_____ Dizziness when standing or sitting
_____ Heart Attack
_____ Hypercholesteremia
_____ Pace Maker
_____ Stroke or CVA
_____ Varicose Veins
_____ Blood Clots
_____ Congestive Heart Failure
_____ Extremities Cold
_____ Heart Disease
_____ Internal Bleeding
_____ Poor Circulation
_____ Swelling of the feet

RESPIRATORY

_____ Asthma
_____ Emphysema
_____ Shortness of Breath
_____ Sleep Apnea/Snoring at night
_____ COPD
_____ Persistant Cough
_____ Shortness of Breath when lying down
_____ Tuberculosis

ENDOCRINE

_____ Cancer
_____ Diabetes II
_____ Goiter
_____ Hypoglycemic
_____ Increased Urination
_____ Unexplained weight loss
_____ Diabetes I
_____ Fatigue
_____ Gout
_____ Increased Hunger
_____ Thyroid Disease

GI

_____ Black Stool
_____ Constipation
_____ Endometriosis
_____ Irritable Bowel Syndrome
_____ Poor Appetite
_____ Vomiting Blood
_____ Bloody Stool
_____ Diarrhea
_____ GERD
_____ Liver Disease
_____ Stomach Ulcer

GU

_____ Frequent Urination
_____ Kidney Stones
_____ Kidney Disease

DERMATOLOGY

_____ Allergies/Hives
_____ Deformed Nails
_____ Ingrown Nail
_____ Skin Disease
_____ Skin Ulceration
_____ Corns/Calluses
_____ Infected Ingrown Nail
_____ Skin Cancer
_____ Skin Lesion/Rash
_____ Thick Nails

MUSCULOSKELETAL

_____ Ankle Sprain
_____ Broken Bones
_____ Bursitis
_____ Fibromyalgia
_____ Hammer Toes
_____ Joint Stiffness
_____ Muscle Pain/Weakness
_____ Pain standing after rest
_____ Painful Toes
_____ Arthritis
_____ Bunion/HAV
_____ Cramping pain while walking
_____ Foot Pain
_____ Heel Pain
_____ Low Back Pain
_____ Osteoporosis
_____ Pain when standing

NEURO

_____ Burning Pain
_____ Numbness
_____ Seizures
_____ Dementia
_____ Pins and Needles/Tingling

HEMATOLOGIC/LYMPHATIC

_____ Anemia
_____ Fever or Chills
_____ Hepatitis B
_____ HIV
_____ Bleeding Disorder
_____ Hepatitis A
_____ Hepatitis C

PSYCHIATRIC

_____ Anxiety
_____ Depression
_____ Bi-Polar Disorder
_____ Paranoia

MEDICATION LOG

Patient _____ Birthdate_____

Pharmacy_____ Phone No._____

Medication	Dosage	QTY	Frequency

Patient's Parents Information

January 1, 2015 Insurance Companies are requiring us to gather additional information. Please fill out this form to the best of your knowledge. Thank you.

Mother's Name: _____

Mother's Birth Date: ____/____/_____

Is your Mother Deceased? _____

Does/Did your mother smoke? _____

Father's Name: _____

Father's Birth Date: ____/____/_____

Is your Father Deceased? _____

Does/Did your father smoke? _____