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 individual's work 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: _____**
Detailed Message_____ Call Back number only_____

□ **Cell Phone:_____**
Text Message_____ Phone call_____

Written and / or Electronic communications:

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

The following individuals may access to my "Personal Health Information" PHI.:

Name	**Phone Number**	**Relationship**

ACKNOWLEDGEMENT 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

21111 Middlebelt Rd, Farmington Hills MI 48336 PH: 248-478-1150
11650 Belleville Rd, Belleville MI 48111 PH: 734-699-2400

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Patient Information

Please Print

_____

Last Name **First Name** **Middle initial**

Mailing
Address: _____

City:_____ **State**:_____ **ZIP**:_____

Phone #: _____ **Alternate #**: _____

DOB: _____ **Gender: MALE FEMALE** **SSN**:_____

Martial Status: S M W D
If insurance is in spouses/ partner's name, what is their :

Name:_____ DOB: _____ Phone:_____

Email:_____

IF the patient is a MINOR:

_____

PARENTS FIRST NAME **Last Name**

Parents SSN:_____ DOB:_____

PATINET AUTHORIZATION FOR PAYMENT

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.

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

X_____ _____ _____

Signature **Relation** **Date**

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Medical History

Height: _____ft _____ in 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 : _____ Ph: _____

Allergies to Medications:_____

_____

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 of 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.

_____ _____
Printed Name Date

X_____
Patient Signature

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Medical Conditions

Please check **ALL** that apply

ENT/EYES
___ Cornea Abrasion
___ Dry Eye
___ Deviated Septum
___ Glaucoma

CARDIOVASCULAR
___ Arrhythmia
___High/Low Blood Pressure
___Dizziness when standing or sitting
___Heart attack
___High Cholesterol
___Pace Maker
___Stroke or CVA
___Varicose Veins
___Blood Clots
___Congestive Heart Failure
___Cold Extremities
___Heart Disease
___Internal Bleeding
___Poor Circulation
___Swelling feet

GU
___Frequent Urination
___Kidney Stones
___Kidney Disease

DERMATOLOGY
___Allergies/ Hives
___Deformed Nails
___Ingrown nails
___Skin Disease
___Skin Ulceration
___Corns/Calluses
___Infected Ingrown nail
___Skin Cancer
___Skin Lesion/Rash
___Thick Nails

Respiratory
___Asthma
___Emphysema
___Shortness of Breath
___Sleep Apnea/Snoring at night
___COPD
___Persistent Cough
___Shortness of breath when lying down
___Tuberculosis

Musculoskeletal
___Ankle sprain
___Broken Bones
___Bursitis
___Fibromyalgia
___Hammer Toes
___Joint stiffness
___Muscle Pain/weakness
___Pain with standing
___Painful Toes
___Arthritis
___Bunion/HAV
___Cramping pain while walking
___Foot Pain
___Heel Pain
___Low Back Pain
___Osteoporosis
___Pain with standing

Endocrine
___Cancer
___Diabetes Type I ___Type II___
___Goiter
___Hypoglycemic
___Increased Urination
___Unexplained Weight Loss
___Fatigue
___Gout
___Increased Hunger
___Thyroid Disease

GI
___Black stool
___Constipation
___Endometriosis
___IBS
___Poor Appetite
___Vomiting Blood
___Diarrhea
___GERD
___Liver Disease
___Stomach Ulcer

NEURO
___Burning pain
___Numbness
___Seizures
___Dementia
Pins and Needles/ Tingling

HEMATOLOGIC/ LYMPHATIC
___ANEMIA
___Fever /Chills
___Hepatitis A
___Hepatitis B
___Hepatitis C
___HIV
___bleeding disorder

PSYCHIATRIC
___Anxiety
___Depression
___Bi-Polar Disorder
___Paranoia

MEDICATION LIST

Pharmacy: _____ Pharmacy #:_____

Pharmacy address:_____

Medication Name Dosage Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's Parents Information

Do/DID your parents or family member have:
Heart Disease____ Diabetes _____ Hypertension_____ Cancer ___

Is your Father living? Yes_____ No_____
Is your Mother living? Yes_____ No_____