NORTHVILLE FAMILY FOOT SPECIALISTS
42925 W. Seven Mile Road
Northville, Michigan 48167

Date _____

WELCOME TO OUR OFFICE

PATIENT HISTORY

— PLEASE PRINT When Filling Out This Form —

Patient's Name _____ /Spouse _____

Address _____
Street City State Zip

Home Phone _____ Business Phone _____

Date of Birth _____ Age _____ Marital Status _____

Occupation _____ Employer _____

Student ☐ Full time ☐ Part time Name of School _____

Guardian's Name (if patient is a minor) _____

Address (if different than patient's) _____

Person to contact in case of emergency _____ Phone _____

Referred by _____

*Patient's Social Security# _____ *Insured's Social Security# _____

Insured by _____ Insured's Name _____

*Insured's Date of Birth _____

Group# _____ Contract# _____

Medicare# _____ Medicaid# _____

*Co-insurance paid through ☐ Business or ☐ Privately

What is your foot problem _____

_____

When did this problem start _____

Have your had foot treatment before _____ If yes, by whom _____

What was the treatment _____

_____

How have you treated this problem at home _____

Have you injured your feet before, and if so, how _____

What type of work do you do _____

Please answer the following questions to the best of your ability:

Your: Height _____ Weight _____ Shoe Size _____

You are in: ( ) good health ( ) fair health ( ) poor health

Are you subject to prolonged bleeding or healing difficulties _____

Do you bruise easily _____ Do you have low back pain _____

Are you under the care of a doctor ( ) yes ( ) no If yes, state the reason: _____

_____

Physician's name and address _____

Are you on a diet _____

What medications are you now taking _____

_____

Are you pregnant ( ) yes ( ) no

Do you: smoke (amount) _____ drink alcohol (amount) _____

( ) I am not allergic to anything to my knowledge
( ) I am allergic to (Please check)

_____ Aspirin	_____ Mercurials	_____ Sutures	
_____ Novocaine	_____ Merthiolate	_____ Other	_____
_____ Codeine	_____ Iodine		_____
_____ Demerol	_____ Adhesives/Tape		_____
_____ Penicillin	_____ Nylon, Plastics		_____
_____ Sulfa	_____ Antihistamines		_____
			_____

Please check appropritate places. I have, or have had the following:

_____ Diabetes	_____ Asthma	_____ Anemia
_____ Bleeding tendencies	_____ Cancer	_____ Tumors
_____ Epilepsy	_____ Glaucoma	_____ Gout
_____ Heart trouble	_____ Kidney trouble	_____ High blood pressure
_____ Nervousness	_____ Rheumatism/Arthritis	_____ Stomach ulcers
_____ Stroke	_____ Tuberculosis	_____ Polio
_____ Varicose Veins	_____ Leg Cramps	_____ Arteriosclerosis
_____ Hepatitis	_____ HIV positive	_____ Aids

If you have not had diabetes, are you aware of any family member who has had it? _____ If so, who? _____

_____

Have you received a blood transfusion prior to March of 1985? If so, please explain _____

Is there anything else we should know? _____

_____

I hereby give permission to Dr. _____ to treat my foot condition.

Date: _____

_____
Signature of patient

_____
Parent or guardian (if patient is a minor)

ACKNOWLEDGMENT 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 (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

o I Permit the Practice to discuss my PHI with, and to disclose my PHI to, the following individuals:

- o My spouse_____
- o My adult child(ren)_____
- o My personal representative_____
- o Other_____

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

Oral communication:

- o Home Telephone_____
  - o O.K. to leave message with detailed information.
  - o Leave message with call-back number only.
- o Work telephone_____
  - o O.K. to leave call-back number Only.

AUTHORIZATION OF MEDICAL RELEASE

I hereby authorize Northville Family Foot Specialists to release the complete history of records in my possession concerning my treatment for insurance claims pertaining to payments. I understand I am financially responsible for any balance not covered by the authorization.

Signed _____