community foot centers, p.c.

Highland Office
2997 East Highland Rd.
Highland, MI 48356

_____
Date

Patient's Name _____ Spouse _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Business Phone _____

Date of Birth _____ Marital Status _____

E-mail Address _____

Occupation _____ Employer _____

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

Address (if different than patient's) _____

Emergency Contact Person _____ Phone _____

Referred By _____

Insurance (Please supply a copy of your insurance card(s) for our records) _____ Subscribers Birth Date _____

What is your foot problem? _____

_____

When did this problem start? _____

Have you 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 _____

Are you in: ( ) Good Health ( ) Fair Health ( ) Poor Health

Are you subject to prolonged bleeding or healing difficulties? _____

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

_____

Physician's name and phone number: _____

Preferred pharmacy and phone number: _____

Please supply medication list: _____

_____

Are you pregnant? ( ) yes ( ) no

( ) 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	_____ Antihistamine		_____

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

_____ Diabetes	_____ Cancer	_____Gout	_____ Rec. Drugs
_____ Epilepsy	_____ Glaucoma	_____Stomach Ulcers	_____ Other
_____ Heart Trouble	_____ Leg Cramps	_____Tobacco	
_____ Stroke	_____ Anemia	_____ Alcohol	

Surgeries: _____

_____

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

_____

Is there anything else we should know? _____

_____

Date _____ _____

Signature of patient

_____

Parent or guardian *(if patient is a minor)*

GENERAL REVIEW OF SYSTEMS:

Are you currently experiencing any of the following?

Genitourinary
Kidney Disease ☐Y ☐N
Urinary Tract ☐Y ☐N
Infection ☐Y ☐N
Blood in Urine ☐Y ☐N
Stones ☐Y ☐N
Sexually Transmitted Disease ☐Y ☐N
Other_____

Cardiovascular
Chest Pain ☐Y ☐N
High Blood Pressure ☐Y ☐N
Elevated Cholesterol ☐Y ☐N
Irregular Heartbeat ☐Y ☐N
Other_____

Psychologic
Depression ☐Y ☐N
Bi-Polar Disorder ☐Y ☐N
Manic Depressive ☐Y ☐N
Anxiety ☐Y ☐N
Other_____

Endocrine
Hot Flashes ☐Y ☐N
Excessive Thirst ☐Y ☐N
Too Hot/Too Cold ☐Y ☐N
Thyroid Problems ☐Y ☐N
Other_____

Gastrointestinal
Constipation ☐Y ☐N
Nausea/Vomiting ☐Y ☐N
Hernia ☐Y ☐N
Abdominal Pain ☐Y ☐N
Other_____

Eyes
Blurred Vision ☐Y ☐N
Double Vision ☐Y ☐N
Other_____

Constitutional Symptoms
Fever/Chills ☐Y ☐N
Weight Loss ☐Y ☐N
Fatigue ☐Y ☐N
Anorexia ☐Y ☐N
Other_____

Neurological
Numbness ☐Y ☐N
Burning ☐Y ☐N
Tingling ☐Y ☐N
Sciatica ☐Y ☐N
Headache ☐Y ☐N
Tremors ☐Y ☐N
Dizziness ☐Y ☐N
Seizures ☐Y ☐N
Other_____

Musculoskeletal
Flank Pain/CVA Tenderness ☐Y ☐N
Back Pain ☐Y ☐N
Joint Stiffness ☐Y ☐N
Joint Pain ☐Y ☐N
Other_____

Hematologic/Lymphatic
Bleeding Tendencies ☐Y ☐N
Swollen Glands ☐Y ☐N
Lymphoma/Leukemia ☐Y ☐N
Other_____

Integumentary
Skin Rash ☐Y ☐N
Boils ☐Y ☐N
Skin Infection ☐Y ☐N
Other_____

Ears, Nose & Throat
Hearing Problems ☐Y ☐N
Sore Throat ☐Y ☐N
Swallowing Issues ☐Y ☐N
Other_____

Allergy/Immunological
Seasonal Allergies ☐Y ☐N
Other_____

Respiratory
Shortness of Breath ☐Y ☐N
Wheezing ☐Y ☐N
Frequent Cough ☐Y ☐N
Pneumonia ☐Y ☐N
Other_____

PATIENT NAME_____ **DATE**_____

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

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.