FENTON FOOT CARE – 14229 Torrey Rd Ste 1 Fenton MI 48430

To submit prior to appointment send via fax, 810-629-9243 or email, info@FentonFootCare.com

Patient Last Name **Patient Legal First Name** **Middle Initial**

Patient Date of Birth
/ /

Gender
☐ Male ☐ Female

Parent/Guardian Last Name **Parent/Guardian Legal First Name** **Relationship to Patient** **Parent Social Security #** **Parent DOB**

Address (No PO BOXs): Street **City** **State** **Zip**

Home Phone
(_____) _____-_____

Cell Phone**
(_____) _____-_____

Email: _____

Parent Occupation _____ **Parent Employer** _____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired ☐Unemployed ☐ Student

Emergency Contact Name
_____

Relationship
☐ Spouse ☐ Parent ☐ Other: _____

Best Phone Number
(_____) _____-_____

Family Doctor _____ **Town** _____ **Office Phone** (_____) _____-_____

How did you hear about our office? _____

What brings you in today? _____ **How Long?** _____

Primary Ins. Carrier: _____
Name of policy holder: _____
Policy Holder DOB: _____

Secondary Ins. Carrier: _____
Name of policy holder: _____
Policy Holder DOB: _____

Privacy Information

Where may we contact/leave message(s): **HOME** ☐ YES ☐ NO **CELL** ☐ YES ☐ NO

Name of person(s) who can have access to the patient's records/PHI or pick up items for the patient:

Name_____ Relationship _____
Name_____ Relationship _____
Name_____ Relationship _____

Attest

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify Fenton Foot Care immediately of any changes to the above information and annually upon the office's request. I also acknowledge that I have been provided the opportunity to take and review the office's HIPAA Policy, Authorization from Patient or Legal Representative, and Notification of Office Policies and Procedures (version 01-01-2017). (Available in our waiting room and/ or by request). I further acknowledge and accept all the terms and conditions outlined in all forms listed including "notifications of office policies and procedures", "HIPAA policy notice of privacy practices", and " authorization from patient or legal representative". I authorize Fenton Foot Care to contact me via text and email. (MSG & date rates may apply)

_____ _____ _____ _____

Print Patient's Name or Legal Representative | Signature | Relationship to Patient | Date

CURRENT MEDICAL HISTORY

Patient Last Name _____ **Patient *Legal* First Name** _____

Patient Shoe Size _____**Weight**_____**Height**_____ **Is Patient Diabetic** ☐Yes ☐No

Physician that follows your diabetic care _____ **Date last seen by them**_____

Current Conditions – mark NONE if the condition below does NOT apply to you

Symptoms: ☐**None** ☐Chills ☐Fever
☐Nausea ☐Vomiting

Neurological: ☐**None** ☐Numbness/ Nerve Pain
☐Seizures ☐Strokes

Skin: ☐**None** ☐Cellulitis/Infection ☐Fungal Nails
☐Ingrown Nails ☐Sores ☐Rash ☐Warts

Vascular: ☐**None** ☐Leg/Calf Cramping ☐Cold Feet
☐Leg/Calf Cramping at rest ☐Skin red/ pale / purple

Allergies – mark NONE if the allergies below do not apply to you

☐**None** ☐Adhesive/tape ☐Anesthetics ☐Aspirin ☐Blood thinners ☐Codeine ☐Dairy ☐Eggs ☐Erythromycin
☐Demerol ☐IV contrast dye ☐Iodine ☐Latex ☐Penicillin ☐Seafood ☐Sulfa ☐Other: _____

Current Medications

Medication List can be copied & attached separately if available – You do NOT have to rewrite medications

Medication	Dosage	How Often	Medication	Dosage	How Often
☐**None**					

Pharmacy you prefer to use

Pharmacy: _____ **Location:** _____ **Zip:** _____

Past Medical History – mark NONE if the history below does NOT apply to you

☐**None**	☐CAD	☐Gastric reflux	☐Liver disease	☐Seizures
☐AIDS/HIV	☐Cancer (Type) _____	☐Glaucoma	☐Lung disease	☐Skin disease
☐Abnormal heart beat	☐ Chronic back pain	☐Gout	☐Multiple sclerosis	☐Stroke
☐Anxiety	☐Chemotherapy	☐Heart attack	☐Neuropathy	☐Thyroid disorder
☐Asthma	☐Circulation problems	☐Hepatitis (Type___)	☐Osteoarthritis	☐ Ulcers/Sores
☐Bleeding disorder	☐Dementia	☐High Cholesterol	☐ Parkinson's disease	☐ Other _____
☐ Blood clot	☐Depression	☐High blood pressure	☐ Rheumatoid arthritis/ autoimmune disease	_____
	☐Diabetes	☐Kidney disease		

Social History

Smoking History ☐ Non Smoker
☐ Current Smoker
Packs per day _____
☐Former smoker
Years of cessation _____

Alcohol History
☐**None**
☐Social
☐Occasional
☐Heavy

Family History

Place An "X" on all applicable lines	**Father**	**Mother**	**Both**
No significant family medical conditions	____	____	____
Unknown family history	____	____	____
Diabetes	____	____	____
Heart Attack	____	____	____
Cancer	____	____	____
Other _____	____	____	____

Responsible Party – for minors (under 18) or patients under medical Power of Attorney/Guardianship

Responsible Party

***The primary individual who accompanies a child (18 or under) to Fenton Foot Care is responsible for all fees, regardless of guardianship or custody arrangements.** All patients 18 or under must be accompanied by an adult, Responsible Party, at every appointment. If the patient arrives unaccompanied to any appointment the patient will not be seen and the appointment will be rescheduled to a time when the patient can be accompanied by a responsible adult.

As the responsible party, if you are unable to bring the patient to their appointment you can approve up to (3) alternate adults that you consent to bring the patient to their appointments and make medical decisions for the patient in your absence. We will not be able to see the patient if they are not accompanied by a parent or an approved alternate adult listed below. Please note that all approved parties must be prepared to pay copayment, co-insurance and/or outstanding balances when applicable.

MEDICAL CONSENT FOR A MINOR CHILD

I _____, the parent or legal guardian of the following child

_____ (child's name and date of birth) hereby consent and allow the following to handle any type of medical treatment for office visit, procedures and treatments.

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

This authorization is effective from _____ (date) and will not expire unless the parent or guardian asks for the consent to be removed.

Signature: _____**Date:** _____

Printed Name: _____

_____	_____	_____	_____
Print Patient's Name or Legal Representative	Signature	Relationship to Patient	Date