Associated Podiatrists, P.C.
26750 Providence Parkway
Suite 130 - Novi, MI 48374
Telephone: (248)348-5300

PLEASE FILL OUT COMPLETELY Today's date _____________

Name (First, Middle, Last):_________________________________ DOB: ___________________

Home Address: ____

City___________________________ State ______ Zip _____________ SS# ______-_____-_____

Primary Number: _____________________________ please specify: ☐ Home ☐ Cell ☐ Other

Secondary Number: ___________________________ please specify: ☐ Home ☐ Cell ☐ Other

Employer: _________________________________ Work Number: ________________________

Circle One: Male Female Circle One: Married Divorced Widowed Single

Email Address: ___________________________________@ ______________________________

Primary Insurance: _________________ Subscriber's DOB/Relationship: ___________________

Secondary Insurance: _________________ Subscriber's DOB/Relationship: _________________

Pharmacy: Address (list crossroads if known) ____

Pharmacy Phone Number: _______________________________ City: _____________________

Emergency Contact (Please list name, relationship and contact number)

1) ____

2) ____

General Health (Circle): Excellent Good Fair Poor

Primary Care Physician's Name, Address, Phone: _______________________________________

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Previous Podiatric History____

Previous Surgical History____

Height _____________________ Weight_________________ Shoe Size ___________________

Are You Allergic to Any of the Following?

Penicillin: Yes____ No____ Codeine: Yes ____ No____ Local Injections/Anesthetics: Yes____ No____

Any other Drug Allergies? If so, please list: ____

I consent to allow Associated Podiatrists, P.C. to pull my pharmacy and drug utilization history for purposes of my medical treatment.

Signature: ____________________________________

Do you have or have you ever had any of the following? **Please answer both columns with a YES or NO.**

Yes	No	Hepatitis (What Type?) ______________	Yes	No	HIV Positive/AIDS
Yes	No	Chest Pains	Yes	No	Persistent Cough
Yes	No	Heart Murmur	Yes	No	Genetic Problems
Yes	No	Ulcers	Yes	No	Sexually Transmitted Disease
Yes	No	Anemia	Yes	No	Gonorrhea, Syphilis
Yes	No	Stroke	Yes	No	Genital Herpes
Yes	No	Hormonal Problems	Yes	No	Epilepsy, Seizures
Yes	No	Problems with bruising easily	Yes	No	Sinus Trouble
Yes	No	Tuberculosis, Lung Disease	Yes	No	Neurologic Disorders
Yes	No	Excessive Urination and/or Thirst	Yes	No	Skin Disease
Yes	No	Prolonged Bleeding Problems	Yes	No	Cancer (Form) ________________
Yes	No	Sickle Cell Anemia	Yes	No	Unexplained Fevers
Yes	No	Prosthetic Valves/Joints	Yes	No	Enlarged Lymph Nodes
Yes	No	Jaundice (Liver Disease)	Yes	No	Persistent Diarrhea
Yes	No	Allergies/Hives	Yes	No	Arthritis
Yes	No	Rheumatic Fever	Yes	No	Pacemaker
Yes	No	Kidney Problems (Please List) ________	Yes	No	Blood Transfusion
Yes	No	Diabetes	Yes	No	Chronic Transfusions
Yes	No	Glaucoma	Yes	No	Prolonged Sore Throat
Yes	No	Psychiatric Problems (Please List):	Yes	No	Night Sweats
		________________________________	Yes	No	Bluish-Reddish Lesions

Yes No Heart Problems (Disease, Surgery, Attack, Congenital Heart Defects)
Yes No Allergy or sensitivity to any metals?
Yes No History of cold sores, fever blisters, or canker sores?
Yes No Are you being treated with immunosuppressive drugs? (Please List) ______________________
Yes No Do you smoke or chew tobacco?
How many glasses of alcohol do you consume a week? ______________________
Yes No Have you ever used drugs for recreational purposes? ______________________
Yes No Do you have any pierced body parts? (Please List) ______________________
Yes No Postural Hypotension (fainting spells)
Yes No Abnormal Blood Pressure (HIGH LOW)
Yes No Have you ever been informed that you must be pre-medicated for surgery?
Yes No Do you have any disease, condition or problem not listed? (Please List) ______________________

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Referred By: ____

Present Complaint: ____

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I hereby give permission to an Associated Podiatrists, P.C. Podiatrist and Assistants as may participate with my treatment to examine and treat my feet medically, surgically, or orthopedically, and release information to my physicians and/or insurance companies.

Signature: ______________________________ Date: ____________________

MEDICATION RECORD____________________________

Patient Name: ______________________________ Allergies: _________________________________

Please list ALL medications you are currently on:

Date	Medication	Dosage	Frequency	#	# Refills	Generic Y/N	Initial

Financial Policy for Associated Podiatrists, P.C.

We appreciate your confidence in choosing Associated Podiatrists, P.C. Please review our financial policy below.

About Co-Payments:
If you are an enrollee of a health insurance plan (HMO or PPO) that we are contracted with, you are required to pay the co-payment if there is an office visit, each time you are seen. This must be paid on the day you are seen. If you are not prepared to pay the co-payment, the visit must be rescheduled.

About Annual Deductibles:
In addition to the co-payment, some plans also have an annual deductible. If you have not met your deductible you will be billed when your insurance rejects the claim. If you have Master Medical, you are responsible for payment since you will receive a check from your insurance company, payable to the subscriber of the policy. In the event there is a balance due from you after your insurance carrier has paid its portion we will bill you. We would appreciate prompt payment of your bill after the first statement. If you do not understand the reason you owe a balance, please do not hesitate to contact our office, and the billing staff will explain the balance to you, and answer any questions you might have.

About Referrals:
If you are enrolled in an HMO, which requires a referral from your Primary Care Physician, you must have a referral with you in order to be seen by the physician. Many HMO's require 5 to 7 days to process a referral. If you arrive with no referral, you have two options:

1) You can reschedule.

2) You may pay for the visit and procedures (including orthotics) at the time of services. Treatment will be provided for the specified procedure requested by your primary physician only. It is your responsibility to keep track of the number of visits remaining on your referral and the date it expires. Please keep a copy for your records.

About Procedures requiring the use of Laboratories (ie: Blood work, biopsies, cultures):
It is your responsibility to inform us if a specific laboratory is required. If we send the laboratory work to the wrong lab we may bill you. Our primary laboratory is St. Johns Health Laboratory. We appreciate your assistance in working with our staff.

Insurance Authorization and Assignment

Professional services rendered by Associated Podiatrists, P.C. are the ultimate responsibility of the patient (and/or guardian). Associated Podiatrists, P. C. will assist in facilitating reimbursement from third party carriers by verifying coverage when necessary. However, by verifying coverage, the extent of that coverage is not a guarantee for payment of the rendered treatment. Therefore, any uncovered or unpaid service is the complete responsibility of the patient (and/or guardian) to pay Associated Podiatrists, P.C. in a timely and acceptable time frame.

I hereby authorize Associated Podiatrists, P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and any co-pays delineated by my policy.

Acknowledgement of Receipt 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: ____ Date: _______________________

Patient Signature (Parent if a minor): _________________________________