

The Foot Care Institute of Michigan
Macomb Professional Building
11885 E. 12 Mile Road, Suite 202B
Warren, MI 48093
586-755-4242 (P)
586-755-6231 (F)

The Foot Care Institute of Michigan
10798 Belleville Rd.
Belleville, MI 48111
(734) 699-2400 (P)
(734) 699- 3669 (F)

The Foot Care Institute of Michigan
21111 Middlebelt Road
Farmington Hills, MI 48336
248-478-1150 (P)
248-478-1156 (F)

MEDICAL HISTORY

HT _____ WT _____ Shoe Size _____ Age _____

Please describe your foot problem _____

_____ Duration _____

Have you been under the care of a medical doctor in the past two years, if so why? _____

Have you been in the hospital in the past two years, if so why? _____

Physician's Name _____ Phone No. _____

Are you currently taking any medications, please list _____

Allergies : _____

Do you smoke? Y N Drink alcohol? Y N Amt _____ Use recreational drugs? Y N

Do you bleed or bruise easily _____

Women: Are you currently pregnant _____

Please check any of the following which you or family member have had or have at present:

Use **F** for Family member or **S** for Self

_____ AIDS	_____ Diabetes	_____ Rheumatic Fever
_____ Anemia	_____ High Blood Pressure	_____ Glaucoma
_____ Asthma	_____ Hepatitis	_____ Cancer
_____ Arthritis	_____ Heart Disease/Attack	_____ Emphysema
_____ Hemophilia	_____ Liver Disease	_____ Allergies/Hives
_____ Varicose Veins	_____ Epilepsy/Seizures	_____ Kidney Disease
_____ Blood Clots	_____ Skin Disease	_____ Skin Ulcers
_____ Stomach Ulcers	_____ Drug Addiction	_____ Fainting/Dizzy spells
_____ Stroke	_____ Poor Circulation	_____ Osteoporosis
_____ Alzheimer's	_____ Thyroid Disease	_____ Gout

Do you have any disease, condition, or problem not listed _____

List previous surgeries and any complications _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or medications, I will inform the doctor at the next appointment.

DATE _____ NAME (print) _____

SIGNATURE _____

Charles Young, D.P.M., FACFAS
Marshall Solomon, D.P.M., FACFAS
Jeffrey Y. Yung, D.P.M., FACFAS
Susan P. King, D.P.M., AACFAS
Nathan M. Stone, D.P.M.



**THE FOOTCARE INSTITUTE
OF MICHIGAN**

PATIENT AUTHORIZATION FOR PAYMENT

PATIENT NAME: _____ DATE: _____

Payment is subject to the terms of your insurance policy and can only be determined at that time the claims are processed. If for any reason your insurance carrier denies your claim, you accept responsibility to pay the entire balance or any remaining balance.

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

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____