Personal Foot Care

David S. Ungar, DPM

34435 Grand River Ave
Farmington, MI 48335
Phone: 248-477-3301
Fax: 248-478-2829

Patient Information **Today's Date: _____**

Name:_____ DOB:_____ SSN:_____

Address_____ City:_____ State: _____Zip:_____

Primary Phone:_____ Alternative Phone:_____ Email:_____

Preferred method of contact: □ call □ text □ email How did you hear about us: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widow

Primary Care Physician: _____Phone:_____

Pharmacy:_____ Cross Roads: _____ Phone:_____

Occupation: _____Employer: _____

Emergency Contact: _____ Relationship: _____Phone: _____

What are you being seen for today: _____

Height _____ Weight _____Shoe Size_____

Do you currently use tobacco products? ☐ Yes, packs: _____ ☐ No ☐ previously, how long: _____

Do your currently use Alcohol products? ☐ Yes ☐ No, How Often? _____

Do you currently use recreational drugs? ☐ Yes ☐ No

Please list any allergies:

1)_____ 2)_____

3)_____ 4_____

Please list any and all medication you take: (prescription, birth control pills, herbs & over-the-counter)

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

7)_____ 8)_____

9)_____ 10)_____

Please list any previous surgeries:

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

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Past Medical History- Please check all that apply:

ENT/EYEs
____ Cornea Abrasion
____ Dry Eye
____ Deviated Septum
____ Glaucoma

CARDIOVASCULAR
____ Arrhythmia
____ Blood pressure abnormality
____ Dizziness when standing
____ Heart Attack
____ High Cholesterol
____ Pace Maker
____ Stroke or CVA
____ Varicose Veins
____ Blood clots
____ Congestive Heart Failure
____ Cold Extremities
____ Heart disease
____ Internal Bleeding
____ Poor circulation
____ Swelling of feet

Respiratory
____ Asthma
____ emphysema
____ shortness of breath
____ Sleep apnea/snoring at night
____ COPD
____ persistent cough
____ Tuberculosis

DERMATOLOGY
____ Allergies/hives
____ Deformed nails
____ Ingrown nails
____ Skin disease
____ skin ulceration
____ Corns/callouses
____ Skin cancer
____skin lesion/rash
____ thick nails

ENDOCRINE
____ Cancer
____ Diabetes II
____ Goiter
____ Hypoglycemic
____Increase urination
____ Unexplained weight loss
____ Diabetes I
____ Fatigue
____ Gout
____ Increase hunger
____ Thyroid Disease

GI
____ Black Stool
____ Constipation
____ Endometriosis
____ IBS
____ Poor appetite
____ Vomiting Blood
____ Blood stool
____ Diarrhea
____ GERD
____ Liver disease
____ Stomach Ulcer

GU
____Frequent urination
____ Kidney Stones
____ Kidney disease

HEMATOLOGIC/LYMPHATIC
____ Anemia
____ Fever or chills
____ Hepatitis B
____ HIV
____ Bleeding disorder
____ Hepatitis A
____ Hepatitis C

PSYCHIATRIC
____ Anxiety
____ Depression
____ Bi-Polar disorder
____ Paranoia

MUSCULOSKELETAL
____ Ankle Sprain
____ Broken Bones
____ Bursitis
____ Fibromyalgia
____ Hammertoes
____ Joint Stiffness
____ Muscle pain/weakness
____ Pain standing after rest
____ Arthritis
____ HAV/bunion
____ Cramping w/ walking
____ Foot Pain
____ Heel Pain
____ Low back pain
____ Osteoporosis
____ Pain when standing

NEUROLOGICAL
____ Burning pain
____ Numbness
____ Seizures
____ Dementia
____ Tingling/pins & needles
____ dizziness

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Authorization:
I authorize payment of insurance benefits to Personal Foot Care. I agree that I shall be legally responsible for any medical or surgical charge incurred in the course of my treatments, includes those that are applied to deductible, co-pay or non-covered/ unpaid services. I understand that in the event I have a delinquent balance of 30 days, my account may be subject to finance charges of 5% and collection fees totaling 35% of my balance.

Release of Information:
I authorize Personal Foot Care to release any and all medical information to my health insurance company necessary to process and pay any claim/claims

Consent for Treatment:
I voluntarily consent to receive all such medical treatment that my medical provider considers beneficial to me. I understand that this care may includes diagnostic tests, examinations, medical or surgical treatment. I am aware that the Practice of Medicine is not an exact science and I hereby acknowledge that no guarantees have been made to me as to the results of treatment and exams provided.

_____

Signature of Patient or Legal Guardian Date

The "Health Insurance Portability and Accountability Act" (HIPAA) gives individual the rights to request a restriction on use and disclosure of "Personal Health Information" (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as correspondence to the individuals works instead of home.

The Privacy Rule generally requires Healthcare providers to take steps to limit their use and disclosure of your PHI.

NOTE: Use and Disclosure of emergencies may be permitted without prior consent

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

☐ Home Phone:_____
☐ Cell Phone: _____
☐ Work Phone: _____

☐ Okay to leave a basic message with callback number only
☐ Okay to leave a detailed message with specific information

The following individuals may have access to my "Personal Health Information" (PHI)

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing my name below, I acknowledge that I received a copy of this office's "NOTICE OF PRIVACY PRACTICES" outlining how my confidential PHHI will be used, disclosed and protected.

X_____ _____
Patient Signature Date