Kent Podiatry

Doctor of Podiatric Medicine

Michael F. Emiley, D.P.M.

Physician and Surgeon of the Foot and Ankle

1238 Fuller Ave, NE | Grand Rapids, MI 49505 |

Phone: (616) 452-0467 Fax: (616) 452-8885

www.emileyfootcare.com

PATIENT

First Name:	Middle Name:	Last Name:	
Social Sec. #:	Date of Birth:	Age:	Sex: M F T
Email:			
Home Address:	City:	State:	Zip:
Home Phone: ( )	Cell Phone :( )	Work Phone: ( )	
(Please provide mailing address if different from above):			
Race: (Optional)	Ethnicity: (Optional)	Primary Language:	Marital Status: S M D W
Occupation:	Employer:		
Employer Address:			
In Case of Emergency contact:			
Relationship	Phone: ( )		

PRIMARY PHYSICIAN

Name:	Phone: ( )
Last Seen?	Referred by:

PREFFERED

Name of Pharmacy:	Phone: ( )		
Address (or cross streets):	City:	State:	Zip Code:

INSURANCE

Name of Policy Holder:	DOB: / /	Relationship:
Primary Insurance:	Phone:( )	
Subscriber #:	Group #:	
Secondary Insurance:	Phone:( )	
Subscriber #:	Group #:	

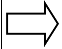
I hereby assign my insurance benefits to be paid directly to Kent Podiatry and I am responsible for any unpaid balance. I authorized the release of any medical information necessary to process all claims. I understand it is my responsibility to call my insurance company to make sure I am covered for all my office visits and to see if a prior authorization or referral is needed before I am seen. I understand that Kent Podiatry may be in network with my insurance company however my plan may be a non network plan. Tis sad but true, Kent Podiatry can't see you for free and Insurance payments are not Kent Podiatry's responsibility. Kent Podiatry accepts cash, credit cards and or checks. All patient billing is due upon services or within 30 days. Patient is responsible for over 90 days past is due on all insurance billings. One half of orthotics fee is due before ordering the orthotics, with the balance due upon receipt of them regardless of your insurance. Full 100% fees are billed to your insurance company. At times, assignment is accepted and a lesser estimated fee reimbursement is entered on your statement card. Do not confuse this with mistaken billing. All of your billing questions will be explained to you. Sorry if you're insurance does not cover @ 100%. Medicare does not cover foot services such as arch taping, supports and materials. I the undersigned, authorized Dr. Emiley and staff to Examine and treat my feet medically, surgically, or bio-mechanically, including performing minor procedures.

PATIENT SIGNATURE:_______________________ **DATE:** ____________

PARENT/GUARDIAN SIGNATURE:_______________________ **RELATION:** ____________

IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT

What do you want the doctor to look at or discuss today? **Example: Right foot pain in the center and side ,swelling**



Height	Weight	Shoe Size

When did your symptoms begin?

What treatments have you tried?

Any Serious injuries in the past? **Yes No** When? How?

Have you seen another Podiatrist for this problem? **Yes No** Who? Treatments?

What other foot/ankle problems do/did you have?

Have you ever injured your feet, legs or back? Explain:

Do you participate in sports? **Yes No** What kind?

Shoe Style used for Work?	Shoe Style for Play?
Are you under the care of a medical doctor? **Yes No**	If Yes, Reasons:

CURRENT MEDICAL PROBLEMS (please indicate):

Last time you had a physical	Last time you had blood work?
Blood Pressure?	Blood Sugar?

MEDICATIONS:

What Medications are you currently taking? **If you have a list please bring it with you, we will make a copy, then there is no need to fill this section**

1	2	3	4
5	6	7	8

( ) To my knowledge I am not allergic to any medications or latex

( ) I am allergic to:

Adhesives/Tape	Demerol	Latex	Seasonal Allergies
Antihistamines	Environmental Allergies	Novacaine/Xylocain	Sulfa
Antibiotics	Iodine	Nylon/Plastic	Sutures
Codeine	Keflex	Penicillin	Other :

SOCIAL

Are you pregnant or trying to become pregnant?		Are you on a Diet?
Have you had the Flu Vaccination? YES NO YEAR	Have you had the Pneumonia Vaccination? YES NO	Do you have a living will or someone to make decisions on your behalf? YES NO

Do you Smoke? Yes No Never	Yes? How many years? ____________	How many packs a day? _
Do you Drink? Yes No Never	Yes? How often? _____________	How many drinks per week? _

Do you use or have history of using any Illicit Drugs? Yes NO Never	Yes? What Type of Drugs?

SURGICAL HISTORY
List past surgeries and reason for hospitalizations:

Appendectomy	Foot/Ankle	Nerve	Vasectomy
Arthroscopic Knee	Gall Bladder/GI	Number of Live Births	Other:
Back	Hernia	Number of Pregnancies	
Cataract/Eye	Hysterectomy	Tonsils and Adenoids	
Fracture Repair with Surgery	Knee/Hip	Tubal Ligation	

Name:

PAST MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems by placing an "X" on the LEFT of the problem:

	DIABETES		**Eye**		**Heart/Circulation**		**Musculoskeletal**
	How long?		Blind in one eye		A-Fib		Arthritis (OTHER THEN FOOT)
	Last A1C?		Cataracts		Bleeding Disorder		Back pain
	Last Blood Sugar?		Dry Eye		Blood Clots		Cortisone treatment (1 yr)
	Ear, Nose, & Throat		Glaucoma		Blood Thinners		Gait/Walking problems
	Difficulty Swallowing		Macular Degeneration		Chest Pains		Gout
	Diminished Hearing				Congestive Heart Failure		History of Fractures
	Ringing in the ears		**General Health**		Heart Attack		Implant
	Endocrine/Immunologic		Cancer		Heart Murmur		Joint or Bone
	Anemia		Type:		Heart Disease		Joint Replacement
	Athlete's Foot		Chemo?		High Blood Pressure		Leg Cramps
	Eczema		Radiation?		Pacemaker		Muscle pain while walking
	Frequent Infections		High Cholesterol		Rheumatic Fever		Pain Radiating down legs
	Hepatitis: A B C (please circle one)		Sickle Cell		Stroke		Rheumatism
	HIV Infection/AIDS		Other:		Valve Problem		**Neurological/Psychiatric**
	Itchy Skin				Varicose Veins		ADD/ADHD
	MRSA		**Gastrointestinal/Genitourinary**		Weakness		Anxiety
	Psoriasis		Blood in Stool				Bipolar Disorder
	Rash		Diarrhea		**Lung/Respiratory**		Burning Sensation
	Thyroid		Enlarged Prostate		Asthma		Depression
	Foot Problems		GERD		COPD		Electric Shocks
	Arthritis		Jaundice		Emphysema		Epilepsy
	Bunion		Kidney Disease		Sleep Apnea		Nervousness
	Bunionette		Liver Disease		Shortness of breath		Numbness
	Flat Fleet		Nausea		Tuberculosis		Schizophrenia
	Fungal Nails		Stomach Ulcers				Seizures
	High Arched Feet		Urinary Problems				Tingling
	Pigeon-Feet		Vomiting				Tremors

FAMILY HISTORY

CIRCLE ALL THAT APPLY FATHER (F), MOTHER (M), BROTHER (B), SISTER (SS), SON (S), OR DAUGHTER (D)

F M B SS S D	Arthritis	**F M B SS S D**	Flat Feet	**F M B SS S D**	Pigeon-Feet
F M B SS S D	Bleeding Disorder	**F M B SS S D**	Gout	**F M B SS S D**	Stroke
F M B SS S D	Bunion	**F M B SS S D**	Heart Trouble	Other:	
F M B SS S D	Bunionette	**F M B SS S D**	High Arched Feet		
F M B SS S D	Cancer	**F M B SS S D**	High Blood Pressure		
F M B SS S D	Diabetes	**F M B SS S D**	High Cholesterol		

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as patient request and/or:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Kent Podiatry is not required to agree to the restrictions requested. I understand that I make revoke this consent in writing, except to the extent that Kent Podiatry has already taken action in reliance thereon. Kent Podiatry cannot be responsible for what your personal Representative does with your health information that is provided under this authorization. Kent Podiatry does not place conditions for treatment on the use of this statement.

The following persons listed are allowed to obtain treatment information and/or billing information associated with my treatment at Kent Podiatry:

SPOUSE: ______________________________ PARENT: ______________________________

CHILD: ______________________________ CHILD: ______________________________

EMPLOYER: ______________________________ OTHER: ______________________________

I choose to not allow anyone to obtain treatment information and/or billing information associated with my treatment at Kent Podiatry other then as listed above.

If I am unable to be reached, I give permission to have messages regarding my appointment time, changes of, or scheduling information left as follows: (check all that apply)

_____ On answering machine/voice mail _____ with family member _____ at work _____ via Email ______________________________

I fully understand and accept the terms of this consent

______________________________ ______________________________ ______________

Patient Name (Please Print) Patients Signature Date

______________________________ ______________________________ ______________

Parent/Guardian (Please Print) Parent/Guardian Signature Date

IF PATIENT IS A MINOR (UNDER 18) OR UNABLE TO SIGN OWN CONSENT

*This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information and verifying your wish to continue the authorization.