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**

Patient's First Name		Middle Name	Last Name
Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address
Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

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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)_____________________________________

Past Medical History

☐ Aids/HIV	☐ Chest pain	☐ Hypertension	☐ Stroke
☐ Allergies	☐Circulatory problems	☐ Hypotension	☐ Stomach ulcer
☐ Alcoholism	☐ Diabetes, HgbA1C _______	☐ High Cholesterol	☐ Hypothyroidism
☐ Anemia	☐Depression	☐ Joint disorder	☐Hyperthyroidism
☐ Angina	☐Ear problems	☐ Kidney disorder	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ Liver disorder	☐ Varicose veins
☐ Anxiety	☐ Glaucoma	☐ Measles	☐ Venereal disease
☐ Asthma	☐ Foot or leg cramps	☐ Migraines	☐ Weight loss, unexplained
☐ Back problems	☐ Gout	☐ Osteoporosis	☐ Weight gain, unexplained
☐ Bleeding Disorder	☐ Heart disease	☐ Psychiatric problems	☐ Alzheimer's disease
☐Blood disease	☐ Hemophilia	☐ Radiation treatment	☐ Dementia
☐Cancer, (type) _________	☐Hepatitis - A, B, or C	☐ Respiratory disease	☐ Other, ________________
☐Chemical Dependency	☐ Hiatal Hernia	☐ Acid reflux/GERD	

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Have you received the influenza vaccination in the past 12 months? ☐ Yes ☐ No

Have you previously received the pneumonia vaccination? (65 or older) ☐ Yes ☐ No

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

Do your currently use Alcohol products? ☐ Yes ☐ No, How many? ________ ☐ beer, ☐ wine, ☐ liquor

Do you currently use recreational drugs? ☐ Yes ☐ No

Woman Only

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

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