WELCOME TO OUR OFFICE
setfootcare.com
(248) 681-6180

PLEASE FILL OUT COMPLETELY **Today's Date** _____

Name (Last, First, Middle) _____ Age _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

SS #: _____ Email: _____

Employer: _____

Date of Birth _____ Circle One: M F Circle One: M D W S

Name of Primary Insurance: _____ Subscriber's Name _____

Subscribers Date of Birth: _____ Relationship to Subscriber _____

Name of Secondary Insurance: _____ Subscriber's Name _____

Subscriber's Date of Birth: _____ Relationship to Subscriber _____

Pharmacy Name: _____ Pharmacy Address _____

Pharmacy Phone Number: _____ Pharmacy Fax: _____

Emergency Contact's Name and Number:

1) _____

2) _____

General Health (Circle): Excellent Good Fair Poor

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

_____

Previous Podiatric History: _____

Previous Surgical History: _____

Height _____ Weight _____

Are you allergic to any of the following?

Penicillin: Yes No Codeine: Yes No

Local Injections/Anesthetics: Yes No Name _____

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

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Are you taking any medications right now? Yes ○ No ○
If Yes, please complete the medication record on the next page.

Do you have or have you ever had any of the following? Please answer Yes or No

Yes ○ No ○ Hepatitis (what type?) _____
Yes ○ No ○ Chest Pains
Yes ○ No ○ Heart Murmur
Yes ○ No ○ Ulcers
Yes ○ No ○ Anemia
Yes ○ No ○ Stroke
Yes ○ No ○ Hormonal Problems
Yes ○ No ○ Problems with bruising easily
Yes ○ No ○ Tuberculosis, Lung Disease
Yes ○ No ○ Excessive Urination and/or Thirst
Yes ○ No ○ Prolonged Bleeding Problems
Yes ○ No ○ Sickle Cell Anemia
Yes ○ No ○ Prosthetic Valves/Joints
Yes ○ No ○ Jaundice (Liver Disease)
Yes ○ No ○ Allergies/Hives
Yes ○ No ○ Rheumatic Fever
Yes ○ No ○ Kidney Problems
Yes ○ No ○ Diabetes
Yes ○ No ○ Psychiatric Problems
Please List _____
Yes ○ No ○ Glaucoma
Yes ○ No ○ HIV Positive/AIDS
Yes ○ No ○ Persistent Cough

Yes ○ No ○ Genetic Problems
Yes ○ No ○ Sexually Transmitted Disease
Yes ○ No ○ Gonorrhea, Syphilis
Yes ○ No ○ Genital Herpes
Yes ○ No ○ Epilepsy, Seizures
Yes ○ No ○ Sinus Trouble
Yes ○ No ○ Neurologic Disorders
Yes ○ No ○ Skin Disease
Yes ○ No ○ Cancer (Form) _____
Yes ○ No ○ Unexplained Fevers
Yes ○ No ○ Enlarged Lymph nodes
Yes ○ No ○ Persistent Diarrhea
Yes ○ No ○ Arthritis
Yes ○ No ○ Pacemaker
Yes ○ No ○ Blood Transfusion
Yes ○ No ○ Chronic Transfusions
Yes ○ No ○ Prolonged Sore Throat
Yes ○ No ○ Night Sweats
Yes ○ No ○ Bluish-Reddish Lesions
Pertinent Family History

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? _____
Yes ○ No ○ Do you smoke or chew tobacco?
How many glasses of alcohol to you consume a week? _____
Yes ○ No ○ Have you ever used drugs for recreational purposes? _____
Yes ○ No ○ Do you have any pierced body parts? Please indicate location: _____
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?
Women: Pregnant? Yes ○ No ○ Nursing? Yes ○ No ○ Taking birth control? (Type) _____
Yes ○ No ○ Do you have any disease, condition or problem not listed. If yes, please describe:

Referred By: _____

Present Complaint _____

I hereby give permission to a S.E.T. Footcare, 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 my insurance companies.

Signature: _____ Date: _____

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S.E.T Footcare, P.C.

3901 Highland Road
Suite D
Waterford, Michigan 48328
(248) 681-6180

Dear Patient,

We appreciate your confidence in choosing S.E.T. Footcare, P.C. Please take a moment to 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 (i.e.: Blood work, biopsies, cultures)

It is your responsibility to inform us if a specific laboratory is requested. 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 out staff. Please sign below and return this to our staff.

I have read and understand my obligation.

I hereby authorize S.E.T. Footcare, P.C. to release to our insurance company(s) or its representative any information, including the diagnosis and records of any treatment or examination rendered to me during the period of such medical and/or surgical care.

Signature _____ Date Signed _____
If patient is a minor, parent's signature

Professional services rendered by S.E.T. Footcare, P.C., are the ultimate responsibility of the patient (and/or guardian). S.E.T. Footcare, P.C. will assist in facilitation 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 S.E.T. Footcare, P.C. in a timely and acceptable time frame.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize S.E.T. Footcare, P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(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.

Signature _____

Date _____

MEDICATION RECORD

Patient's Name: _____ Allergies: _____

Date of Birth: _____ Age: _____

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

S.E.T. FOOTCARE, P.C.

Acknowledge 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 Signature _____ Date _____

Please print name _____

Parent or Authorized Representative (if applicable):

Signature _____ Date _____

Please print name _____

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