10 W. Square Lake Rd., Suite 300
Bloomfield Hills, MI 48302

2035 Monroe
Dearborn, MI 48124

Bloomfield Family Foot Care

New Patient Registration Form

PATIENT INFORMATION

Name (Last, First, Middle): _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Phone: (_____)_____ Email Address: _____

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse (Last, First, Middle): _____ Maiden: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____)_____

If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name: _____ Phone: (_____)_____

INSURANCE INFORMATION

Insurance Company: _____ ID#: _____

Group:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

DOCTOR & PHARMACY REFERENCES

Primary Care Physician: _____ Date last seen: _____

If Diabetic, Endocrinologist:_____ Date last seen:_____

Preferred Pharmacy: _____

Pharmacy Location (City & Major Intersection): _____

Reason for Visit:_____

Shoe Size:_____

PAST MEDICAL HISTORY

Reason for Visit: _____

Shoe Size: _____ Have you ever worn orthotics? YES or NO

Please List All Current Medications, Dosage, and Duration: _____

_____

_____

MEDICAL HISTORY CONTINUED

Have you received your flu vaccination this year: YES OR NO

If you are 65 and over have you had a pneumonia vaccination? YES OR NO

Do you smoke cigarettes? YES OR NO

If so, number per day: _____

Do you have a living will? YES OR NO

AUTHORIZATION

I certify that the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to **Bloomfield Family Foot Care. I acknowledge** that I am responsible for payment if my insurance company denies my claim.

_____ _____

Patient Signature Date

_____ _____

Parent or Legal Guardian Signature (If patient is a minor) Date