

Family Foot Center

1221 Byron Road, Suite 3 ● Howell, Michigan 48843 ● Phone (517) 548-3100 ● Fax (517) 548-4594
7305 E. M-36 ● P.O. Box 878 ● Hamburg, Michigan 48139 ● Phone (810) 231-8500 ● Fax (810) 231-8501
7575 Grand River Avenue, Suite 203 ● Brighton, Michigan 48116 ● Phone (810) 227-7722 ● Fax (810) 227-7721

PLEASE PRINT

PERSONAL INFORMATION

SS#	BIRTHDATE	SEX M / F	MAIDEN NAME
PATIENT LAST NAME	FIRST	CELL PHONE	
ADDRESS	CITY	STATE	ZIP
EMPLOYER	ADDRESS	WORK PHONE:	
SPOUSES NAME	CELL PHONE	OTHER PHONE:	
SPOUSES EMPLOYER	ADDRESS	WORK PHONE:	
EMERGENCY CONTACT/NEXT OF KIN	DAYTIME PHONE: NUMBERS:		

NURSING HOME PATIENTS PERSON RESPONSIBLE FOR BILL:	PHONE:
ADDRESS:	

INSURANCE INFORMATION

DO YOU HAVE INSURANCE?	YES	NO	IF YES, DO YOU HAVE A SECONDARY INSURANCE?	YES	NO
NAME OF INSURANCE	GROUP #	CONTRACT OR SS#			
NAME OF CARD HOLDER	BIRTHDATE	RELATIONSHIP TO PATIENT			
SECONDARY INSURANCE	GROUP #	CONTRACT OR SS#			
NAME OF CARD HOLDER	BIRTHDATE	RELATIONSHIP TO PATIENT			

MEDICAL INFORMATION

REFERRED BY	FAMILY PHYSICIAN					
WORK RELATED? YES NO	TYPE OF PROBLEM	DATE BEGAN				
AUTO RELATED? YES NO						
GENERAL HEALTH GOOD FAIR POOR	DATE OF LAST TETANUS	HEIGHT	WEIGHT	SHOE SIZE		
PLEASE CHECK ALL YOU HAVE OR HAVE HAD:						
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Gout	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Cancer
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Polio
<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Tumors
PLEASE CHECK ALL THAT YOU ARE ALLERGIC TO: IF NO ALLERGIES CHECK HERE <input type="checkbox"/>						
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Novocaine	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Merthiolate	<input type="checkbox"/> Iodine	
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Anesthetics	<input type="checkbox"/> Seconal	<input type="checkbox"/> Mercurials	<input type="checkbox"/> Adhesive	
<input type="checkbox"/> Codeine	<input type="checkbox"/> Demerol	<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Nylon/Plastic	<input type="checkbox"/> Latex	<input type="checkbox"/> Darvon	
<input type="checkbox"/> Other _____						
<input type="checkbox"/> Current Medications: _____						

INSURANCE AUTHORIZATION

I hereby authorize Dr. Isidore Steiner and his associates to release all medical information, which may be necessary to my insurance company. I hereby assign to Dr. Steiner and his associates, all benefits provided by my insurance policy for medical/surgical care. I also understand that I am financially responsible for all charges regardless of my insurance coverage. I understand that a duplicate copy of this authorization may be used and is as acceptable as the original and may not be revoked unless a request is submitted by me in writing.

Date _____ Signature of Patient (Parent if minor) _____
Signature of Cardholder _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Isidore Steiner and his associates for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Date _____ Signature of Patient _____

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TO ALL PATIENTS WITH INSURANCE

PLEASE READ THIS FORM CAREFULLY

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company and not your insurance company and your doctor. Although we fill out insurance forms, the patient is ultimately responsible for payment of services rendered.

I have read and understand to above statement:

Signature of patient or patient representative

Date