Sparrow Medical Group,
Charlotte 111
111 Lansing St. Suite 100
Charlotte, MI 48813
phone **517.485.7300**

Delta Foot Care, P.C.
Brian S. Goosen D.P.M.
3802 W. Kalamazoo
Lansing, MI 48917
phone **517.485.7300**
fax 517.485.7301
email: deltafootcare@att.net

Bluewater Medical Center
2001 E. Bluewater Hwy.
Ionia, MI 48846
phone **517.485.7300**

Thank you for allowing us to be involved in your health care. You are scheduled to see Dr. Goosen at Delta Foot Care, P.C. on:

_____ at _____ am / pm.

Enclosed you will find registration forms that we would like you to fill out as completely as possible. Please return these to the window when you arrive for your appointment. (If there is adequate time, please mail back to the office. It may be necessary to keep a copy for your records).

On the day of your appointment we ask that you bring the following items:

- **This completed paperwork**
- **All of your insurance cards**
- **Valid picture identification**
- **Appropriate insurance authorization from your primary care provider, if required by your insurance company**

Payment for services rendered is expected at the time of service. Please be prepared to pay any applicable copays and/or deductibles. As a reminder it is your responsibility to know the amount of your copay. For those without insurance we ask that you be prepared to pay at the time of service.

We look forward to meeting you.

Delta Foot Care Doctor and Staff

Delta Foot Care, P.C.

Brian S. Goosen D.P.M.
3802 W. Kalamazoo
Lansing, MI 48917
phone **517.485.7300**
fax 517.485.7301
email: deltafootcare@att.net

Patient Name _____ Employer _____

Preferred name _____ Occupation _____

Date of Birth _____ Employment Status Full Time Part Time Unemployed

Home Address _____ SS# _____

City _____ State Zip _____ Primary Care Physician Full Name _____

Phone # _____ Sex M F _____ Phone # _____

eMail Address _____ Referral Source Doctor Family Friend _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced _____ Emergency Contact _____

Phone # _____

Insurance

Primary Insurance: _____

Contract #: _____ Group #: _____ Copay: _____

Contract Holder: _____ Date of Birth: _____

Secondary Insurance: _____

Contract #: _____ Group #: _____

Contract Holder: _____ Date of Birth: _____

Person/Parent Responsible for Bill *Required for Minors*

Guarantor Name: _____ Social Security Number: _____

Relationship to Patient: _____ Date of Birth: _____

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

Medications (☐ I have attached a list)

Please list all medications and the dosages, including over the counter

_____

_____

_____

Allergies

Allergy to:

____ Medications: _____

____ Foods: _____

____ Tapes: ____ Novocaine ____ Anesthetics ____ Silver/Nickel/Costume Jewelry ____ Latex Other: _____

What types of reactions have you experienced?

_____

_____

Do you have a history of any of the following:

	Yes	No		Yes	No
Kidney Disease	___	___	High Cholesterol	___	___
Dialysis M W F or T Th SA	___	___	Drug/Alcohol Abuse	___	___
Diabetes A1C _____%	___	___	Epilepsy or Seizures	___	___
Tuberculosis	___	___	Prolonged Bleeding Time	___	___
Emphysema	___	___	Stomach/Ulcer Disorder	___	___
Heart Trouble	___	___	Thyroid/Parathyroid Disease	___	___
Stroke	___	___	High Blood Pressure	___	___
Chest Pain on Mild Exertion	___	___	Arthritis	___	___
Gout	___	___	Rheumatoid Arthritis	___	___
BLOOD CLOTS	___	___	Psychiatric Treatment	___	___
Tumor/Abnormal Growth/Cancer	___	___	Emotional Problems/Tension	___	___
Ear, Nose, Throat Disorder	___	___	Asthma/Hay Fever/Shortness of Breath	___	___
Anemia/Blood Disorders	___	___	Prostate Disorder	___	___
Pneumonia	___	___	Pregnant	___	___

All Surgical History (Wisdom Teeth, Appendectomy, etc.)

Surgical Procedures/Serious Injuries/Illnesses	Year

Has any immediate family member had any of the following

Cancer: _____ Relationship: _____

Diabetes: _____ Relationship: _____

Heart Trouble: _____

High Blood Pressure: _____

Kidney Disease: _____

Mental or Emotional Disease: _____

Stroke: _____

Tuberculosis: _____

Arthritis: _____

Emphysema: _____

BLOOD CLOTS: _____

I was adopted and do not know my biological family history

Patient Information

Do you smoke currently? ___ Yes ___No How many packs per day? _____ For how long? _____

Have you smoked previously? ___ Yes ___No When did you quit? _____

Number of caffeine drinks per day? _____ Amount of alcohol consumed per week _____

Please complete the following:

Height: _____ Weight: _____ Shoe Size: _____

Reason for today's visit

_____

_____

_____

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

✘ _____
Date

✘ _____
Signature

Delta Foot Care, P.C.
Brian S. Goosen D.P.M.
3802 W. Kalamazoo
Lansing, MI 48917
phone **517.485.7300**
fax 517.485.7301
email: deltafootcare@att.net

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE 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.

X _____
Patient Name (Please Print)

_____
Parent or Authorized Representative (if applicable)

X _____ X _____
Signature Date

RELEASE OF MEDICAL RECORDS

_____ I do not give permission for my medical records to be released to anyone other than myself.

_____ Your office may release my medical information to the following people:

_____ _____
Primary Doctor Date

_____ _____
Endocrinologist Date

_____ _____
Name Relationship

_____ _____
Name Relationship

Delta Foot Care, P.C.

Brian S. Goosen D.P.M.
3802 W. Kalamazoo
Lansing, MI 48917
phone **517.485.7300**
fax 517.485.7301
email: deltafootcare@att.net

Release of Information and Assignment of Benefits

I hereby authorize Delta Foot Care, P.C. to release any information necessary for the completion of the medical insurance claim form. I also authorize the release of any additional protected health information requested by my health insurance carrier. Authorization of benefits payable to Delta Foot Care, P.C. is also granted.

I assume responsibility for payment of co-pays, deductibles, and any non-covered services as determined by my health insurance provider.

I am aware that Medicare will cover only certain foot related procedures. Routine foot care such as the trimming of healthy toenails, corns, and callouses are covered only under certain circumstances. Your Podiatrist can advise you as to whether this is a benefit in your case. When covered by Medicare, treatment is limited to once every 61 days. It may also be required that you be evaluated by your primary care physician every 6 months.

X _____ X _____

SIGNATURE DATE