Family Footcare of Mid-Michigan, P.C.
1205 South Mission Street, Suite 11
Mount Pleasant, MI 48858
989-775-8500

Welcome to our practice and thank you for trusting Family Footcare of Mid-Michigan, P.C. and Dr Connie Lee Bills, DPM with your foot care needs. We look forward to providing you with exceptional care.

Please review the instructions below and complete the 2 page form prior to your appointment.

1. Bring up to 5 pairs (if you have them) of footwear that you use both in and out of the house on a regular basis for work/working out/walking/dress/slippers/sports. (Dr Bills can determine the reason for many foot issues by looking at shoes)

2. We have a strict no show policy. If you do not call us by the day prior to your appointment to cancel there will be a charge of $100 to reschedule the appointment. If you are calling after business hours or on the weekend you may leave a message on our voicemail. Not arriving for your visit or canceling your visit the day of hinders the flow of the office and takes up space for other patients who may be in need of foot care services. We will call you the day before your visit to confirm, if we are unable to reach you by phone to confirm we will attempt to send an email if there is one on file. If we are unable to reach you the appointment may be double booked which could create a longer wait time for you. We ask that you call us back by 2:00 PM on the business day to confirm the appointment if you have not already spoken with a member of our staff. Thank you for your cooperation in this!

3. If you have relevant X-rays for your current condition please GET THE DISC prior to your appointment. You as the patient are the only one who may request and receive this disc. If you need x-rays we are able to take them here but it may save you time and money if the disc is picked up prior to your visit.

4. Please note that due to rising Credit Card Processing fees, there will be a 3.5% charge added to all credit/debit card transactions, including HSA cards. There will be no fee assessed for cash or check transactions.

Our address is listed above.

Take Mission street to Preston Street and turn East. Take Preston 1/2 block to Eastwood and turn North. Our building is the 2nd one on the left and displays a “1205 Building” sign. Come in the door with the ramp and we are the first door on the left, Suite 11.

If using a GPS for navigation to your appointment, set the address to 1206 Eastwood, it will bring you directly to the back parking lot.

See you soon!!

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Welcome to our office! Please complete this entire form. If a section doesn't apply to you please write N/A. Thanks!

Patient Name:___________________________________ Date of Birth__________Sex (at birth) M/F

SSN:__________________ Height: _______ Weight: _______ Shoe Size: ____

Address_______________________________________City__________________ZIP code_______

Home Phone: ____________________Mobile: __________________ Work: __________________

Email: ________________________________ Preferred contact? Home/Mobile/Email/Work

Name of parent or partner_____________________ Marital status: S/M/D/W/Sep/Partner

Student status: F/P Occupation: _______________________________do you SIT/STAND/BOTH

Why are you here today?____

How long have you had this?__________ What did you do to treat the problem? ______________

____ Did any treatments help? __________________

Do you have arch support problems? Y/N Have/wear orthotics? Y/N Ingrown Toenails? Y/N

Ethnicity: Hispanic/Latino, NOT Hispanic/Latino Race: White/African American/Asian/Indian/Other

Primary Care Provider: ____________________________ Phone ___________________

May we contact your provider? Yes/No Preferred Pharmacy: ________________City: __________

Allergies to medication and reaction: _____________________________________NO Allergies:__

Current Medications including over the counter, with dosage: ______________________________

____

Current medical conditions list/circle: ____

High Blood pressure	High Cholesterol	Diabetes: type I or II? Last HbA1C? ____
Cancer:__________	Hearing loss	Arthritis:______________
Asthma	Macular degeneration	Psoriasis
Lupus	Gout	Anemia
Vascular (arterial) disease		

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Surgical History: ____

Social History: Sports:_____________ Drink Alcohol? Y/N quantity per week____

Smoke? Y/N or Previous smoker/never smoker   Recreational drug use? ___________________

Family History: Indicate relationship Mother (M)/Father(F) NONE____ Adopted____

Arthritis	Bunion	Diabetes	Gout	Heart Disease
Vascular problem	Flat Feet	Hammertoes	Stroke	Parkinson's

VASCULAR Questions:
1. When walking or exercising do you experience cramping? Y/N Where?____________________
   Does the pain subside with rest? Y/N
2. Do you have any open sores that aren't healing? Y/N
3. Are you Diabetic? Y/N/Not sure
4. Have you experienced temporary loss of vision in one eye? Y/N Slurred speech? Y/N
   Weakness or numbness of arm or leg on one side of the body? Y/N
5. Do you have stents in the leg blood vessels? Y/N In your heart? Y/N

Insurance authorization and Assignment/Financial agreement
I authorize Family Footcare of Mid-Michigan and Connie Lee Bills, DPM, to release any information necessary to process an insurance claim on my/our behalf and further authorize payment directly to the physician for any services rendered. Any co-pay or deductible is payable at the time of visit. I understand there is no guarantee that my insurance company will pay for my office visit or any supplies I may receive.

If I am billed for any amount my insurance did not cover I understand the full amount is due within 30 days. If payment is not received this office will take any measures needed to collect the money and there will be added fees if the account is sent to a 3rd party for collection.

If 24 hours notice of cancellation is not given a fee of $100 for new patient or $50 for existing patient may be assessed and payable only upon rescheduling with this office.

Insurance: ________________ Subscriber: _____________________________ DOB: ________

Relationship to subscriber: self/child/spouse/other:____________ Employer: ________________

Who is responsible for the bill?____

____   __________________________
Signature of patient or guardian   DATE