MICHAEL J. KELLEY, D.P.M.
PATIENT REGISTRATION FORM
(616)874-8772 or (989)291-5546 or (800)554-5124

Patient Name: _____ **Occupation:** _____

Birthdate: _____ **Gender: M___F___ Marital Status: M___ S___ D___ W___**

Address: _____ **City:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Which phone do you prefer to receive calls? _____ **Can we leave a message? Yes____ No____**
Email: _____

Would you like to receive alerts for upcoming appointments: Yes___ No ___ If yes, Email ___ Text ___

Primary Care Doctor: _____ **Location:** _____

Pharmacy: _____ **Location:** _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ **copy of card required**
Policy Holder's Name: _____ Date of Birth: _____
SS#: _____ Relationship to Patient: _____
Employer: _____
Secondary Insurance: _____ **copy of card required**
Policy Holder's Name: _____ Date of Birth: _____
SS#: _____ Relationship to Patient: _____

Responsible Party/Guarantor

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____

Emergency Contact(s):

Name: _____ **Relationship to Patient:** _____ **Phone:** _____
Name: _____ **Relationship to Patient:** _____ **Phone:** _____

PATIENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

The policy of this office is to require payment at the time services are rendered. By signing below, I am stating that I understand this policy. I hereby authorize this office to furnish my designated insurance carrier or Social Security Administration, Health Care Financing Administration or intermediaries any necessary information concerning my present illness or injury. I authorize benefits under all claims to be made payable directly to this office. I understand I am financially responsible to the physician for any charges not covered by the insurer. In addition, I authorize release of necessary medical records to physicians to whom I am referred by this office.

Patient Signature (or Parent/Guardian, if minor): _____ **Date:** _____

MICHAEL J. KELLEY, D.P.M.
Patient Medical History

Name: _____ **Date:** _____

Current Medications (please include strength):

_____

_____

Allergies to Medication: _____

Past Surgical History: _____

_____

Are you pregnant? Yes ___No___
Are you HIV Positive? Yes ___No___
Are you a Hepatitis Carrier? Yes ___No___
Are you a smoker Yes ___No___ **If yes, how much?** _____
Alcohol Use: Yes ___No___ **If yes, how much?** _____

I have/had:

_____ anemia	_____ heart problems	_____ rheumatic fever
_____ asthma	_____ headaches/dizziness/fainting	_____ rheumatism/arthritis
_____ bleeding tendencies	_____ high blood pressure	_____ shortness of breath/wheezing
_____ cancer	_____ kidney/bladder problems	_____ skin conditions
_____ diabetes	_____ knee/hip/lower back pain	_____ stomach ulcers
_____ epilepsy	_____ nervousness	_____ strokes
_____ glaucoma/vision issues	_____paralysis/muscle weakness	_____ tuberculosis
_____ gout	_____ polio	_____ tumors

other: _____

Immediate Family Medical History:

Diabetes_____ **relationship**_____
Cancer_____ **relationship**_____
Heart problems____ **relationship**_____

Shoe size: _____

Please state in your own words your medical reason(s) for coming to our office: _____

_____

**********Doctor's Section**********

Height _____ **Weight** _____

_____

_____

_____

_____