

MICHIGAN FOOT AND ANKLE

Patient History Questionnaire – New Patient

Name _____ Age _____ Date _____

SS # _____ Birthdate _____ Marital Status _____

Address _____

Telephone: Home _____ Work _____ Cell _____

Email _____

Next of Kin/Emergency Contact _____

Emergency Phone # _____

How were you referred to our office? Patient _____ Doctor's office _____ Other _____ Referral _____

Doctor's Name (if checked above) _____

Doctor's Address and Phone# _____

Other (if checked above) _____

Employer _____

Employer Address _____

Employer Phone Number _____

INSURANCE INFORMATION

Type of Insurance _____ Policyholder _____

Policyholder SS# _____ Policyholder Date of Birth _____

Policyholder Address _____

Relationship to Patient _____

Policyholder Employer _____

Employer Address _____

Employer Contact & Phone Number _____

Name _____ Date _____

CHIEF COMPLAINT What brought you to the doctor today?

Is this condition work related? Yes No Did this injury occur at school? Yes No

Is this condition auto related? Yes No Other injury? Yes No

Is there an open claim? Yes No

Past Medical History Do you have a history of any of the following?

- Hypertension Diabetes Stroke Nervousness Tumors
- Heart/Circulation Trouble Hypoglycemia Emphysema Epilepsy Cancer
- Glaucoma Kidney Disease Ulcers DVT HIV/AIDS
- Asthma Liver Disease Rheumatism/Arthritis Anemia Hepatitis
- Bleeding Tendencies Thyroid Disease Varicose Veins Drug Abuse Cholesterol
- Tuberculosis Gout Leg Cramps Mitral Valve Prolapse

Past Surgical History Have you had any surgery before _____ Yes _____ No

If yes, please list procedure and date _____

General Health Good Fair Poor Height _____ Weight _____

Type of Problem

- Corns, Callous, Nails Fracture/Sprains Warts, Tumors Bunions, Hammertoes
- Diabetic Foot Care Ingrown Nail Ankle Pain Neuroma or Nerve Pain
- Heel Pain Other (Specify) _____

Date It Began _____ Home Treatment/Response _____

Allergies Do you have any allergies to medications? _____ Yes _____ No

- Penicillin Sulfa Codeine Demerol Aspirin
- Novocain Tetracycline Darvon Cipro Seconal
- Tetanus Anesthetics Antihistamines Mercurial Eggs
- Merthiolate Adhesives Iodine Nylon/Plastic Motrin
- Non Steroidals Shell Fish Anti-Inflamatoy Other _____

Are you allergic to latex products? _____ Yes _____ No

Medications List all prescription medications you take; include dosage and frequency. Insulin, inhaler And patches should be included here

List all non-prescription medications you take routinely _____

Name _____ Date _____

Social History

Do you smoke _____ Yes _____ No How Much Per Day _____ X _____ Years

Do you drink alcohol _____ Yes _____ No How Much _____

What type of job do you have _____

Family History Do any illnesses run in your family

Mother _____

Father _____

Siblings _____

Review of Systems Please check if you have any of the following

CONSTITUTIONAL

- _____ Fever
- _____ Weight loss
- _____ Lethargy

EARS, NOSE, MOUTH & THROAT

- _____ Tinnitus
- _____ Nose bleeds
- _____ Nasal congestion
- _____ Sore throat
- _____ Difficulty swallowing

GENITOURINARY

- _____ Frequency
- _____ Blood in urine
- _____ Abnormal urine color
- _____ Painful urination
- _____ Awaken to urinate
- _____ Unable to fully empty bladder
- _____ Incontinence

HEMATOLOGIC/ LYMPHATIC

- _____ Easy bruising
- _____ Anemia
- _____ Blood abnormalities
- _____ Blood thinners
- _____ Lymph node enlargement

EYES

- _____ Blurred vision
- _____ Cataracts
- _____ Glasses

RESPIRATORY

- _____ Chronic cough
- _____ Wheezing
- _____ Emphysema
- _____ Cough blood
- _____ Productive cough
- _____ Asthma

MUSCULOSKELETAL

- _____ Pain
- _____ Limited range of motion
- _____ Limited strength
- _____ Arthritis

NEUROLOGICAL

- _____ Headache
- _____ Fainting
- _____ Dizziness
- _____ Memory loss
- _____ Numbness

CARDIOVASCULAR

- _____ Shortness of breath
- _____ Chest pain (angina)
- _____ Heart palpitations
- _____ Heart attack
- _____ Stroke
- _____ Cold extremities
- _____ Hypertension

GASTROINTESTINAL

- _____ Pain
- _____ Diarrhea
- _____ Constipation
- _____ Blood in stool
- _____ Mucus in stool
- _____ Nausea
- _____ Vomiting
- _____ Vomit blood
- _____ Heartburn
- _____ Change in stool
- _____ Food intolerance
- _____ Loss of appetite

INTEGUMENTRY

- _____ Rash
- _____ Itching
- _____ Dry Skin

ENDOCRINE

- _____ Night sweats
- _____ Thyroid disease
- _____ Diabetes

Reviewed _____

Name _____ Date _____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

FINANCIAL RESPONSIBILITY: 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 these changes, it is not always possible. We therefore urge you, the patient, to please check with your insurance company prior to any office visit/procedure. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, or guardian being responsible for all costs incurred. Delinquent accounts may be subject to collection, service fee and/or interest. Non-coverage delinquent fees may be charged a monthly interest of 1.5% per month. Please remember your insurance policy is between you and your company, not the insurance company and your doctor.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized Medicare/Other Insurance Company benefits be made on my behalf to Harvey Lefkowitz, DPM, PC, Highland Milford Foot Specialist, PC, Commerce Foot and Ankle Specialists, PC and Associates, for any services furnished to me by that physician or his associates. I authorize any holder of medical information to release it to the Health Care Financing Administration/Other Insurance Company and its agents any information needed to determine these benefits payable to related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/Other Insurance Company assigned cases, the physician agrees to accept the charge determined as full charge, and the patient is responsible for only the deductible, coinsurance, copays and non-covered services. Coinsurance, deductibles and copays are based upon the charge determination of Medicare/Other Insurance Company.

In the event that my health insurance plan refuses to pay for medically reasonable and necessary services provided, I also assign all my ERISA rights to Harvey Lefkowitz, DPM, PC, Highland Milford Foot Specialist, PC, Commerce Foot and Ankle Specialist, PC and Associates for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for claims-processing violations. This ERISA assignment is in consideration for the unpaid services provided, in consideration for my insurance plan's reduced fee schedule, and in consideration for the continued willingness of Harvey Lefkowitz, DPM, PC, Highland Milford Foot Specialists, PC, Commerce Foot and Ankle Specialist, PC and Associates to see patients, including me, on an insurance assignment basis. I understand that if my treating doctor prevails in any payment dispute, I may be liable for any applicable co-payment for contested services.

ERISA is an acronym for the employee Retirement Income Security Act, which includes federal laws requiring insurance companies to process, submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts of up to \$110.00 a day for each infraction.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any holder of information concerning my treatment to release that information to the Social Security Administration and its intermediaries, insurance carriers or other governmental offices if needed for this or related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record and information related claim for payment. I also authorize release of information concerning care and treatment including copies of my medical record and information relating to treatment for serious communicable diseases, (as defined by the Michigan Public Health Code), to my Health Plan Administrator, its agents and representatives, insurance carrier or its authorized agent, for the purpose of conduction, concurrent or retrospective, of medical review of treatment and services provided at Harvey Lefkowitz, DPM, PC, Highland Milford Foot Specialist, PC, Commerce Foot and Ankle Specialists, PC and Associates. I understand that 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. I hereby give my permission to Harvey Lefkowitz, DPM, PC, Highland Milford Foot Specialist, PC, Commerce Foot and Ankle Specialists, PC and Associates, to administer treatment; and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature _____ Date _____
Patient

Signature _____ Relationship _____
Guardian