MICHIGAN FOOT AND ANKLE

☐ **NEW Patient** **Patient History Questionnaire** ☐ **UPDATE** _____ year

Name _____ Age _____ Date _____

SS # _____ Birthdate _____ Marital Status _____

Address _____

Telephone: Home _____ Work _____ Cell _____

Email _____

What is your primary language? _____

What is your race? (circle one)

1.) American Indian/Alaska native 2.) Asian 3.) Native Hawaiian 4.) Black or African American 5.) White

What is your ethnicity? (circle one)

1.) Hispanic or Latino 2.) Not Hispanic or Latino

Next of Kin/Emergency Contact _____

Emergency Phone # _____

How were you referred to our office? ☐ Insurance Referral ☐ Urgent Care ☐ Internet ☐ Coupon/Advertising ☐ Patient ☐ Doctor's Office ☐ Hospital/ER ☐ Building/Sign

Primary Care Physician _____

Primary Care Physician's Address and Phone# _____

Pharmacy _____ Location _____ Phone# _____

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

Is this condition auto related? ☐ Yes ☐ No

Is there an open claim? ☐ Yes ☐ No

Did this injury occur at school? ☐ Yes ☐ No

Other injury? ☐ Yes ☐ No

Have you been treated for this condition by any other physician? ☐ Yes ☐ No

If so who? _____

If so when? _____

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

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

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

If yes, please list procedure and date _____

General Health ☐ Good ☐ Fair ☐ Poor Last Blood Pressure _____ Height _____ Weight _____

Type of Problem

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

Date It Began _____Home Treatment/Response _____

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

- ☐ Penicillin
- ☐ Novocain
- ☐ Tetnus
- ☐ Merthiolate
- ☐ Non Steroidals
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Anesthetics
- ☐ Adhesives
- ☐ Shell Fish
- ☐ Codeine
- ☐ Erythromycin
- ☐ Antihistamines
- ☐ Iodine
- ☐ Demerol
- ☐ Cipro
- ☐ Mercurial
- ☐ Nylon/Plastic
- ☐ Aspirin
- ☐ Keflex
- ☐ Eggs
- ☐ Motrin

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 _____

Do you drink alcohol _____ Yes _____ No How Much _____

What type of job do you have _____

Family History Do any illnesses run in your family

☐ Negative ☐ Heart Problems ☐ High Blood Pressure ☐ Lung Problems ☐ Diabetes ☐ Thyroid

☐ Anesthesia Problems ☐ Cancer ☐ Cholesterol ☐ Bleeding Disorder ☐ Other_____

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

CONSTITUTIONAL
_____ Fever
_____ Weight loss
_____ Lethargy

EARS, NOSE, MOUTH & THROAT
_____ Tinnitis
_____ 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 .58% 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 basic. 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.

PATIENT CENTERED MEDICAL HOME – NEIGHBORHOOD:
I ACKNOWLEDGE THAT I WAS PROVIDED A PATIENT CENTERED MEDICAL HOME – NEIGHBORHOOD BROCHURE FOR HARVEY LEFKOWITZ D.P.M., P.C.
HIGHLAND-MILFORD FOOT SPECIALISTS, P.C.
COMMERCE FOOT & ANKLE SPECIALISTS, P.C.

Signature _____ _____
Patient Date

Signature _____ _____
Guardian Relationship

Harvey Lefkowitz, D.P.M., P.C.
Highland-Milford Foot Specialists, P.C.
Commerce Foot & Ankle Specialists, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

1. My "Protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I hereby give my consent for Harvey Lefkowitz, D.P.M., P.C., Highland-Milford Foot Specialists, P.C. and Commerce Foot & Ankle Specialists, P.C. to use and disclose PHI about me to carry out treatment, payment and healthcare operations (TPO). (Harvey Lefkowitz, D.P.M., P.C.'s, Highland-Milford Foot Specialists, P.C.'s and Commerce Foot & Ankle Specialists, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.) I understand that Harvey Lefkowitz, D.P.M., P.C., Highland-Milford Foot Specialists, P.C. and Commerce Foot & Ankle Specialists, P.C. may refuse to diagnose or provide treatment if I do not consent to the use or disclosure of my PHI for the above stated purposes. My signature on this document is evidence of this consent.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Harvey Lefkowitz, D.P.M., P.C., Highland-Milford Foot Specialists, P.C. and Commerce Foot & Ankle Specialists, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Harvey Lefkowitz, D.P.M., P.C., Highland-Milford Foot Specialists, P.C. and Commerce Foot & Ankle Specialists, P.C. Privacy Officer at 641 West Nine Mile Rd. Suite A, Ferndale, MI 48220 or Highland-Milford Foot Specialists, P.C. at 1550 N. Milford Rd. Suite 203-A, Milford, MI 48381 or Commerce Foot & Ankle Specialists, P.C. at 3050 Union Lake Rd. Suite 8-B, Commerce Township, MI 48382.

With this consent, Harvey Lefkowitz, D.P.M., P.C., Highland-Milford Foot Specialists, P.C. and Commerce Foot & Ankle Specialists, P.C. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Harvey Lefkowitz, D.P.M., P.C., Highland-Milford Foot Specialists, P.C. and Commerce Foot & Ankle Specialists, P.C. may mail or e-mail to my home or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminders, cards and patient statements. I have the right to request that Harvey Lefkowitz, D.P.M., P.C., Highland-Milford Foot Specialists, P.C. and Commerce Foot & Ankle Specialists, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Harvey Lefkowitz, D.P.M., P.C.'s, Highland-Milford Foot Specialists, P.C.'s and Commerce Foot & Ankle Specialists, P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Harvey Lefkowitz, D.P.M., P.C., Highland-Milford Foot Specialists, P.C. and Commerce Foot & Ankle Specialists, P.C. may decline to provide treatment to me.

I acknowledge that I was provided with a copy of the Summary of Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice. I acknowledge that a full detailed copy of Notice of Privacy Practices is posted in the waiting room for my review. I am entitled to receive a full detailed copy of Notice of Privacy Practices, and will be provided such copy by asking the receptionist for one.

Signature _____ _____
Patient Date

Signature _____ _____
Guardian Relationship