

MICHIGAN FOOT AND ANKLE

NEW Patient

Patient History Questionnaire

UPDATE _____
year

Name _____ Age _____ Date _____

SS # _____ Birthdate _____ Marital Status _____

Address _____ City _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

Email _____

What is your primary language? _____

What is your race?

American Indian/Alaska native Asian Native Hawaiian Black or African American White

What is your ethnicity? Hispanic or Latino Not Hispanic or Latino

Gender: Male Female Other

Next of Kin/Emergency Contact _____

Emergency Phone # _____

May we leave Personal Health Information messages on your phone? Yes No
(If not answered, we will leave a message.)

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

Primary Care Physician or Referring Doctor _____

Primary Care Physician's Address and Phone/Fax # _____

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 a work injury? 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 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?

<input type="checkbox"/> Anemia	<input type="checkbox"/> DVT	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding Tendencies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tumors
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Heart/Circulation Trouble	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Psychiatric History	

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 _____

Have you received the COVID-19 Vaccine? _____ YES _____ NO

Type of Problem

<input type="checkbox"/> Corns, Callous, Nails	<input type="checkbox"/> Fracture/Sprains	<input type="checkbox"/> Warts, Tumors	<input type="checkbox"/> Bunions, Hammertoes
<input type="checkbox"/> Diabetic Foot Care	<input type="checkbox"/> Ingrown Nail	<input type="checkbox"/> Ankle Pain	<input type="checkbox"/> Neuroma or Nerve Pain
<input type="checkbox"/> Heel Pain	<input type="checkbox"/> Other (Specify) _____		

Date it Began _____ Home Treatment/Response _____

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

<input type="checkbox"/> Adhesives	<input type="checkbox"/> Demerol	<input type="checkbox"/> Merthiolate	<input type="checkbox"/> Shell Fish
<input type="checkbox"/> Anesthetics	<input type="checkbox"/> Eggs	<input type="checkbox"/> Motrin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Non-Steroidals	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Novocaine	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Cipro	<input type="checkbox"/> Keflex	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other _____
<input type="checkbox"/> Codeine	<input type="checkbox"/> Mercurial	<input type="checkbox"/> Nylon/Plastic	_____

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 _____

Have you been out of the country recently? ____Yes ____No If so, where? _____

Family History: Do any illnesses run in your family? Mother Father (Check M or F)

- | | | |
|---|---|---|
| <input type="checkbox"/> M <input type="checkbox"/> F - Negative | <input type="checkbox"/> M <input type="checkbox"/> F - Diabetes | <input type="checkbox"/> M <input type="checkbox"/> F - Cholesterol |
| <input type="checkbox"/> M <input type="checkbox"/> F - Heart Problems | <input type="checkbox"/> M <input type="checkbox"/> F - Thyroid | <input type="checkbox"/> M <input type="checkbox"/> F - Bleeding Disorder |
| <input type="checkbox"/> M <input type="checkbox"/> F - High Blood Pressure | <input type="checkbox"/> M <input type="checkbox"/> F - Anesthesia Problems | <input type="checkbox"/> M <input type="checkbox"/> F - Other _____ |
| <input type="checkbox"/> M <input type="checkbox"/> F - Lung Problems | <input type="checkbox"/> M <input type="checkbox"/> F - Cancer | _____ |

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

- _____ Joint Pain
- _____ Neck Pain
- _____ Back Pain
- _____ Limited Range of Motion
- _____ Limited Strength
- _____ Arthritis

NEUROLOGICAL

- _____ Headache
- _____ Fainting
- _____ Dizziness
- _____ Memory Loss
- _____ Numbness
- _____ Bulging or Herniated Disc
- _____ Sciatica

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
- _____ Difficulty taking medicine

INTEGUMENTARY

- _____ Rash
- _____ Itching
- _____ Dry Skin
- _____ Athletes Foot
- _____ Moles/Skin Spots
- _____ Warts on Feet

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. Non-coverage delinquent fees may be charged a yearly interest rate of 7%. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all cost, and expenses, including reasonable attorneys' fee, we incur in such collection efforts. Please remember your insurance policy is between you and your company, not the insurance company and your doctor. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

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, and Associates, for any services furnished to me by that physician or 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, 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, 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, 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, and Associates, to administer treatment; and to perform such 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, OR MAY ACCESS FROM THE PRACTICE WEB PAGE, A PATIENT CENTERED MEDICAL HOME – NEIGHBORHOOD BROCHURE FOR HARVEY LEFKOWITZ D.P.M., P.C. HIGHLAND-MILFORD FOOT SPECIALISTS, P.C.

Signature _____
Patient Date

Signature _____
Guardian Relationship

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

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
AND
ACKNOWLEDGMENT 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. and Highland-Milford Foot 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 and Highland-Milford Foot 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. and Highland-Milford Foot 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. and Highland-Milford Foot 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. and Highland-Milford Foot 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.

With this consent, Harvey Lefkowitz, D.P.M., P.C. and Highland-Milford Foot 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. and Highland-Milford Foot 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. and Highland-Milford Foot 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 and Highland-Milford Foot 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. and Highland-Milford Foot Specialists, P.C. may decline to provide treatment to me.

I acknowledge that I was provided with or may access from the practice web page 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