SOUTH LYON
FOOT & ANKLE
SPECIALISTS

Physicians and Surgeons of the Foot and Ankle

Patient History Questionnaire — New Patient

Name ______________________ Age ______ DOB ____________

SS# ______________________ Marital Status M S D W

Address ______________________ City ____________ State ______ Zip ________

Telephone: Home ____________ Cell ____________ Work ____________

Emergency Contact (name and phone no.) ______________________

Type of Insurance ____________ Policyholder ____________ Policyholder DOB ____________

How were you referred to our office? Patient ________ Doctor's Office ________ Other ________

Referral Name ______________________

CHIEF COMPLAINT

☐ Corns, Callous, Nails ☐ Fractures/Sprains ☐ Warts, Tumors ☐ Bunions, Hammertoes

☐ Diabetic Foot care ☐ Ingrown Nail ☐ Ankle Pain ☐ Neuroma or Nerve Pain

☐ Other ______________________

Date it began ____________ Home Treatment / Response ______________________

Did this injury occur at ☐ Work ☐ School ☐ Auto ☐ Other

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

☐ Hypertension ☐ Heart/Circulation Trouble ☐ Kidney Disease ☐ Rheumatism/Arthritis ☐ Gout

☐ Diabetes ☐ Hypoglycemia ☐ Ulcers ☐ Bleeding Tendencies ☐ Leg Cramps

☐ Stroke ☐ Emphysema ☐ Asthma ☐ Varicose Veins

☐ Cancer ☐ Glaucoma ☐ Liver Disease ☐ Tuberculosis

☐ Other ______________________

Past Surgical History Have you had surgery before? ☐ Yes ☐ No

If yes, please list procedure and date ______________________

General Health ☐ Good ☐ Fair ☐ Poor Height ____________ Weight ____________

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

☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Demerol ☐ Aspirin

☐ Tetracycline ☐ Darvon ☐ Anesthetics ☐ Adhesives ☐ Iodine

☐ Other ______________________

Are you allergic to latex products? ☐ Yes ☐ No

Medications List all prescription medications and non-prescription.

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____

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? ____________________

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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

INTEGUMENTARY
- ☐ Rash
- ☐ Itching
- ☐ Dry skin

ENDOCRINE
- ☐ Night sweats
- ☐ Thyroid disease
- ☐ Diabetes

Reviewed ____________________

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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 Anthony Mastrogiacomo, DPM, South Lyon Foot & 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 requests 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.

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 Anthony Mastrogiacomo, DP, South Lyon Foot & Ankle Specialists, PC and Associates. I understand that a 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 Anthony Mastrogiacomo, DP, South Lyon Foot & 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 ____
(Patient)

Signature ____
Guardian Relationship

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