MICHFOOT SURGEONS P.C.
www.michfoot.com

Patient Name: _____

Date of birth: ____/____/_____

Address: _____ City: _____ Zip: _____

Home Phone:_____ Cell: _____ Work: _____

Email Address: _____

The best way for us to confirm appointments: ☐ Email ☐ Text ☐ Phone (home/cell/work)

Emergency contact name: _____ Phone #: _____

Relationship:_____

Primary Care Physician name: _____ City:_____

Pharmacy Name and Location (**cross streets/ zip code**):

_____

What type of work do you do? _____

How were you referred to this office? _____

I give my permission for Fred B. Leff DPM/ Randy M. Leff DPM/ Kevin C. Sorensen DPM/ Kristina Green DPM to treat my foot condition. I authorize any and all medical insurances to send payment for services directly to Michfoot Surgeons P.C. I acknowledge that I am responsible for knowing my insurance plan and all inclusions or exclusions in coverage. As such, I understand that I may be responsible for out of pocket expenses that must be paid in a timely manner. Failure to do so may result in cessation of services and my account being turned over to a collection agency.
The Undersigned Patient or legally authorized representative ("Agent") of the patient acknowledges that he/she personally received or was offered a copy of the Michfoot Surgeons PC Privacy Polices on that date indicated below.

Signature of Patient: _____Date:____/____/_____

Signature of Parent/Guardian (if Patient is a Minor): _____

F. Leff DPM R. Leff DPM | Michfoot Surgeons | K. Sorensen DPM K. Green DPM
29201 Telegraph Rd. Suite 100 Southfield, MI 48034
| 248.355.4000 | 248.355.4047 (f) | www.michfoot.com | Michfoot@me.com (e)

History and Physical Form

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Date:_____

Name:_____Age:_____Height:_____Weight:_____Shoe Size:_____

Chief Complaint:

_____

Describe the Symptoms:

_____

Duration of the problem:

_____

Previous or home treatments:

_____

Other Foot Problems: ◻ Bunions ◻ Flat Feet ◻ Hammertoes ◻ Warts ◻ Heel/Arch pain ◻ Ankle pain
◻ Corns/Calluses ◻ Arthritis/Stiffness ◻ Poor Circulation ◻ Neuroma ◻ Ingrown Nails ◻ Fungal Nails
What types of shoes do you normally wear?_____

Past Medical History:

Are you currently or have you been treated for any of the following conditions?

◻ Diabetes ◻ Sickle Cell Anemia/Trait ◻ High Cholesterol ◻ Arthritis ◻ High Blood Pressure
◻ Gout ◻ Heart Disease ◻ Seizures ◻ Stroke ◻ HIV or Hepatitis ◻ Bleeding Disorder
◻ Stomach Ulcers ◻ Asthma ◻ Neuropathy ◻ Blood Clots ◻ Cancer:_____
Other Medical Problems:_____

Family Medical History:

Are or were any blood relatives treated for any of the following conditions?

◻ Diabetes ◻ Amputations ◻ High Blood Pressure ◻ Poor Circulation ◻ Neuropathy
◻ Heart Disease ◻ Ulcerations ◻ Bleeding Disorder ◻ Bunions/Corns/Calluses
Other Medical/Foot Problems:_____

Medications:

Please list all medications that you currently take/ provide a list.

_____

_____

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Past Surgical History:
Please list any surgeries you have had both foot/ankle and body.

Allergies:
Are you allergic to any of the following?

□ Latex □ Tylenol □ Aspirin □ Novocaine/Lidocaine □ Iodine □ Penicillin □ Codeine □ Motrin

□ Cortisone □ Shell Fish □ Sulfa □ Tape □ Darvon □ Demerol □ Keflex

Other allergies:_____

Do you smoke? Yes or No **If yes**, how many packs per day? _____

Do you drink alcohol? Yes or No **If yes**, how many drinks a week? _____

Do you or have you used illicit drugs? Yes or No **If yes**, what kind and how often? _____

Are you or could you be pregnant? Yes or No

Review of Systems:
Are you experiencing any of the following?

Constitutional:
□ decreased appetite □ headache □ weight loss □ feeling the room spinning □ faintness □ fever

□ difficulty breathing when lying flat □ weakness □ weight gain □ dizziness

Cardiovascular:
□ chest/arm pain □ heart palpitations □ low blood pressure □ heart murmur □ heart attack □ varicose veins

□ mitral valve prolapse □ cramps in legs or feet (when sleeping)

Musculoskeletal:
□ joint aches or pain stiffness □ chronic low back pain □ chronic ankle pain □ chronic neck pain □ weakness

□ swelling of joints □ pain in feet in morning □ chronic hip pain □ limited motion in joints □morning stiffness

Integument:
□ allergy to chemicals □ thick/discolored toenails □ cracked skin □ skin cancer □ scarring □ itching/rash

□pain associated with the skin

Neurological:
□ tingling □ pins and needles □ numbness □ shooting pain burning □ radiating pain

□ decreased or lack of sensation to touch □ decreased or lack of sensation to heat or cold

Endocrine:
□ increase or decrease in thirst □ diabetes mellitus □ post menopause □ weight loss or gain

□ thyroid problems □ osteoporosis □ increase or decrease in appetite □ increase or decrease in urination

Hematological/Lymphatic:
□ hemophilia □ weakness □ bruise easily □ sickle cell disease or trait □ leukemia □ anemia

□ blood transfusion reaction □yellow discoloration of skin

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Financial Responsibility Policy of Michfoot Surgeons

Date: ____/____/____

Welcome to our office. Your understanding of our financial polices is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

Co-Pay: The co-pay is an amount that your health plan requires you to pay any time that an office visit is billed. The payment is due on the date of service.

Annual Deductible: An annual deductible is an amount that your health plan requires you to pay toward your health care costs each year. **If you have not met that deductible at the time of service at our office, you will be responsible for payment on that date of service.** We will be able to assist you in determining the amount your deductible has been paid to date.

Balances: If you have paid your deductible, we will bill your insurance, you are responsible for payment to our office for your services. We will charge your onfile credit/debit card if 3 statements are sent and the full balance outstanding balance remains unpaid.
Patients without Insurance: If you do not have insurance, you are responsible for payment on the date of your service.

When Referrals Are Required: Some plans require that your primary physician write a referral to a podiatrist, which indicates conditions are to be evaluated and treated. If you are unsure if a referral is necessary, please check with our office. If a referral is required, it may be faxed or mailed, prior to your visit, or you may bring it with you on the date of your visit. **A referral cannot be applied to the services after they have been provided.**

Past Due: Past due accounts are subject to collection proceedings if statements go unpaid.

Returned Checks: There is a service fee of $25 for all returned checks.

Payment: We accept cash, American Express, Discover, MasterCard, Visa, and checks. We realize life presents us with unforeseen circumstances. We will work with you and set up a payment plan when necessary.

Patient Signature: _____ Date____/____/____

Patient Name Printed: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Date:____/____/____

You May Refuse to Sign This Acknowledgement

I,_____, have received or have been offered a copy of
Patient Name (Printed)

this office's Notice of Privacy Practices.

Patient Signature: _____ Date:____/____/____

Patient Name (Printed): _____

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (please specify):

_____

_____

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