REGISTRATION
(PLEASE PRINT)

BLOOMFIELD FOOT AND ANKLE SPECIALISTS, PLLC.

43750 Woodward Ave., Ste. 102
Bloomfield Hills, MI 48302

Telephone: (248) 738-5550

Date_____ Home Phone_____

Cell Phone _____

Patient _____
Last Name First Name Middle Initial

Responsible Party (if a minor) _____

Street Address _____

City_____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birth Date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security # _____ Spouses Social Security_____

Patient Employed By _____

Business Address _____

Occupation_____ Business Phone _____

Spouse (or responsible party) Name_____ Birth Date _____

Business Address _____

Occupation_____ Business Phone _____

Who is responsible for this account?_____ Relationship to patient _____

Do you have Medical Insurance? ☐ No ☐ Yes ▶ IF YES, PLEASE PROVIDE YOUR INSURANCE CARD AND LICENSE

Who is your primary care doctor? _____

What medications do you take? _____

In case of emergency, who should be notified?_____ Phone _____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____
Name of Insurance Company

and assign directly to BLOOMFIELD FOOT AND ANKLE SPECIALISTS, PLLC. all medical benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to BLOOMFIELD FOOT AND ANKLE SPECIALISTS, PLLC. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the determination of the Medicare carrier.

_____ _____
Signature of Insured/Guardian Date

PATIENT HISTORY QUESTIONNAIRE

NAME:_____ Date of Birth:_____ Today's Date: _____

Doctor(s) who referred you: _____ Phone: _____

Reason for visit: _____

I. HISTORY OF PRESENT ILLNESS (HPI)

PAIN- WHERE?_____ describe it (burn, stab, dull, etc)_____

WHEN does it occur? _____ HOW LONG does it last? _____

How long has it occurred?_____ How SEVERE? _____

What makes it better or worse? _____

NUMBNESS -(tingling, asleep feeling)- WHERE? _____

Describe it (burn, stab, dull, etc)_____

WHEN does it occur? _____ HOW LONG does it last? _____

How long has it occurred?_____ How SEVERE? _____

What makes it better or worse? _____

OTHER COMPLAINTS- _____

II. Past Medical History: *Please circle Yes of No if you have any of the following medical problems?*

Diabetes	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Blood Clots	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No
Breathing Problems	Yes	No	Liver Disease	Yes	No
Bleeding Problems	Yes	No	Cholesterol	Yes	No

Others please list: _____

Past Surgical History:

_____ _____

_____ _____

_____ _____

Medications : (doses and how often you take them)

_____

_____

_____

_____

Allergies/Reactions: _____

_____

Continued on Next Page

Social History:

Tobacco: ☐ Yes ☐ No _____ packs per day for ____ years

Alcohol Use: ☐ Yes ☐ No How much? _____

Illicit Drug Use: _____

Occupation/Hobbies: _____

Right or left hand dominant _____ Marital Status: _____, lives with _____,

use cane, walker or wheelchair _____

Family History: (*List medical problems in your relatives)*

Father: _____ Mother: _____

Siblings: _____ Others: _____

III Review of Systems

Please circle Yes or No if you have any of the following problems?

☐ **Constitutional**			☐ **Ears/Nose/Mouth/Throat**			☐ **Eyes**		
Good General Health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent Weight Change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night sweats, fevers	Yes	No	Nosebleeds	Yes	No	Eye disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No	Glaucoma	Yes	No
☐ **Cardiovascular**			☐ **Respiratory**			☐ **Gastrointestinal**		
Chest pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart Trouble	Yes	No	Wheezing / Asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No
☐ **Musculoskeletal**			☐ **Neurological**			☐ **Integumentary** (Skin)		
Muscle pain or cramps	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/seizures	Yes	No	Easily Bruise	Yes	No
Trouble walking	Yes	No	Numbness tingling	Yes	No	Easily Bleed	Yes	No
☐ **Endocrine**			☐ **Hematologic / Lymphatic**			☐ **Allergic / Immunologic**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food Allergies	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Aspirin Allergies	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Antibiotic Allergies	Yes	No
☐ **Genitourinary -**			☐ **Psychiatric**					
Blood in urine	Yes	No	Insomnia	Yes	No			
Kidney Stones	Yes	No	Confusion/memory loss	Yes	No			
Sexual problems	Yes	No	Depression	Yes	No			
Testicle pain /Menstrual problems	Yes	No						

Patient statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ Date: _____

For Office Use Only:
Physician Statement: I have reviewed the questionnaire with the patient

Signed: _____ Date: _____

BLOOMFIELD FOOT AND ANKLE SPECIALISTS, PLLC.

AHMAD ELHAOULI, D.P.M.
RICK SIEGEL, D.P.M., P.C.

Medicine & Surgery of the Foot & Ankle

43750 Woodward Ave., #102
Bloomfield Hills, MI 48302
Telephone: (248) 738-5550

BILLING POLICY

ALL Office Visit Co--pays, Deductibles and Co-insurance are due at the time of service.

We will attempt to estimate your out of pocket expenses prior to your visit.

ALL Outstanding balances must be paid prior to your next visit.

ALL Balances must be **paid in full** within **30 days** of the original billing statement. There will be a **$10.00 rebilling charge** each time an additional statement is issued for the original charges.

PATIENT FINANCIAL RESPONSIBILITY

You are responsible for payment of any co-payment at the time of service and on the receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to BLOOMFIELD FOOT AND ANKLE SPECIALISTS, PLLC.. for providing services to the patient or me named below. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to BLOOMFIELD FOOT AND ANKLE SPECIALISTS, PLLC.. I agree to pay BLOOMFIELD FOOT AND ANKLE SPECIALISTS, PLLC. the full and entire amount of all bills incurred by me or the patient named below, if applicable, any amount due after payment has been made by my insurance carrier, including any and all fees associated for collection services needed as the result of non-payment.

Signature _____

(relationship to patient: self – guardian – other_____)

Patient Name (printed): _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature