



Great Lakes FOOT & ANKLE SPECIALISTS

DR. JEFFREY SZCZEPANSKI

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www.GreatLakesFoot.com

BRIEF MEDICAL HISTORY FORM

(Please print and complete as fully as possible)

PATIENT'S NAME _____ Date _____

WHAT IS YOUR FOOT PROBLEM? _____

HAVE YOU HAD FOOT TREATMENT BEFORE? _____ IF YES, BY WHOM AND WHAT KIND? _____

HAVE YOU TREATED THIS PROBLEM AT HOME? _____

HAVE YOU INJURED YOUR FEET BEFORE/ IF SO, HOW? _____

WHAT KIND OF WORK DO YOU DO ? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS BEST YOU CAN:

YOUR: HEIGHT _____ WEIGHT _____ SHOE SIZE _____

ARE YOU IN: () GOOD HEALTH () FAIR HEALTH () POOR HEALTH

ARE YOU SUBJECT TO PROLONGED BLEEDING OR HEALING DIFFICULTIES? _____

ARE YOU UNDER THE CARE OF A DOCTOR? () YES () NO IF YES, STATE THE REASON: _____

PHYSICIAN'S NAME AND ADDRESS _____

WHEN WAS THE LAST TIME YOU SAW A DOCTOR? _____

WHEN WAS THE LAST TIME YOU HAD A "COMPLETE" CHECK-UP _____

() I AM NOT ALLERGIC TO ANYTHING TO MY KNOWLEDGE.

() I AM ALLERGIC TO (PLEASE CHECK):

- ___ ADHESIVE TAPE
- ___ ANTIHISTAMINES
- ___ ASPIRIN
- ___ CODEINE
- ___ DEMEROL
- ___ IODINE

- ___ LIDOCAINE
- ___ MERCURIALS
- ___ MERTHIOLATE
- ___ NSAIDS
- ___ NYLON/PLASTICS
- ___ PENICILLIN

- ___ SULFA
- ___ SUTURES
- ___ OTHER

PLEASE EXPLAIN THE TYPE OF "ALLERGIC" REACTION YOU HAVE HAD _____

WHAT MEDICATIONS ARE YOU TAKING? _____

NAME OF YOUR PHARMACY _____

I HAVE (OR) I HAVE PREVIOUSLY HAD THE FOLLOWING:

(PLEASE CHECK): (1) = HAVE (2) = I HAVE PREVIOUSLY HAD

<input type="checkbox"/> ANEMIA	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> LOWER BACK PAIN
<input type="checkbox"/> ARTERIO SCLEROSIS	<input type="checkbox"/> GOUT	<input type="checkbox"/> POLIO
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> STOMACH ULCERS
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> STROKE
<input type="checkbox"/> BLEEDING TENDENCIES	<input type="checkbox"/> HIGH BLD PRESSURE	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> VARICOSE VEINS
<input type="checkbox"/> CANCER	<input type="checkbox"/> JOINT REPLACEMENT	<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> DIABETES	<input type="checkbox"/> KIDNEY TROUBLE	
<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> LEG CRAMPS	

EXPLAIN ANY OF THE ABOVE CONDITIONS YOU HAVE HAD: _____

HAVE ANY OF YOUR FAMILY MEMBERS HAD DIABETES OR OTHER SERIOUS CONDITIONS?

ARE YOU PREGNANT () YES () NO LAST MENSTRUAL PERIOD _____

DO YOU EXERCISE? () YES () NO IF YES, HOW MUCH? _____

DO YOU SMOKE? () YES () NO IF YES, HOW MUCH? _____ HOW LONG? _____

IF YOU QUIT, WHEN DID YOU QUIT? _____ HOW LONG DID YOU SMOKE? _____

Alcoholic beverages (including beer and wine): How many drinks per day? _____

Do you use illicit drugs such as marijuana, cocaine...? () YES () NO Explain _____

PLEASE LIST ALL OF THE HOSPITALIZATIONS AND SURGERIES YOU HAVE HAD:

IS THERE ANYTHING ELSE WE SHOULD KNOW? _____

_____/_____/_____
DATE

SIGNATURE OF PATIENT

PERSON GIVING INFORMATION/RELATION

PARENT OR GUARDIAN



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Financial and Office Policies

What is a co-pay and deductible? Why do I have to pay my co-pay and/or deductible?

A co-pay is the small amount you have to pay to access medical care according to your insurance contract. In some cases, it might be \$5-\$30 but with some insurances, it would be a percentage of your bill (10% is common). This is supposed to provide a slight incentive for you to visit the doctor less and thereby avoid overuse of medical services. Medicare patients don't pay a co-pay "up front", but they are responsible for a small portion of the bill.

A deductible is the amount of money that a patient must pay out of pocket before the insurance carrier is responsible for any charges. The average deductible ranges from \$100 to \$2000 and once this has been met the insurance company will begin to pay for covered services. Medicare patients are responsible for their deductible at the beginning of each year; commonly any secondary insurance will cover this amount.

When you sign up with an insurance carrier, you basically sign a contract which stipulates that you are obligated to pay your co-pay and/or deductible in certain instances. That usually means that you are required to pay a co-pay and/or deductible for all office visits, including follow-up examinations, outpatient surgical procedures, whether done in our office or hospital.

Disability/Time off work and all other forms

Please allow adequate time for disability forms, workman's compensation forms, etc, to be filled out by the doctor. Our policy requires a 3 business day turn around on all forms and a \$5 fee. We are able to complete forms the same day for a \$25 fee. Any note you need that is written on a prescription pad is provided free of charge.

I, the undersigned, certify that I (or my dependent) have insurance with _____

Name of Insurance Company (ies)

and assign directly to Great Lakes Foot & Ankle Specialists, PLLC., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible to pay all charges that are not covered by my insurance, including by not limited to, co-pays, deductibles, and non-covered services. I further understand I am responsible for any collection and/or legal fees incurred in the collection of any past due charges. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

The undersigned Patient or Legally Authorized Representative (Agent) of the Patient acknowledges that he or she was made aware of Great Lakes Foot and Ankle Specialists Notice of Privacy Policies on the date indicated below.

PATIENT NAME _____

SIGNATURE _____ DATE ____ / ____ / ____

Information about Agent or POA (attach appropriate documentation)