MILLENNIUM FOOT & ANKLE SPECIALISTS
STACEY B. SCHWARTZ, DPM, PLC
PHILIP M. WATKINS, DPM
32255 NORTHWESTERN HIGHWAY, SUITE 195
FARMINGTON HILLS, MI 48334

PLEASE NOTE OUR TELEPHONE # (248) 419-3550

Welcome To Our Office . . . .

Please **print** and complete the following information for our files.

Last Name	First	Middle Initial	Today's Date

Residence Address Apt. #	City	State	Zip	Marital Status Single Married Widowed Divorced

Patient's Birthdate	Patient's Social Security Number	Patient's Employer

Home Phone Cell Phone	Age	Sex Male Female	Business Phone

Whom may we thank for referring you to our office?	Address/City/State

Spouse's Name, Parent's or Guardian's Name if a Minor	Birthdate	Social Security Number of Spouse, Parent or Guardian

Name, address and phone number of person outside your home to contact in case of emergency?	Relationship

Person responsible for account - If other than patient please list name, address, birthdate and relationship to patient

Do you have medical insurance? Yes No	Insurance Company Name	Subscriber Name, Social Security Number and Birthdate

Is insurance through your employer? Yes No	Is there a second insurance company? Yes No	Second Insurance Company Name	Subscriber Name, Social Security Number and Birthdate

List any medical conditions you have	Subscriber's Employer

Name of family physician	Phone	Are you currently under this physician's care? Yes No

If yes, for what	May we contact your physician for your health records? Yes No Address

Previous treatment by a podiatrist? No Yes Name?	When?	For what?

Patient's height	Weight	Shoe size	Occupation

Reason for today's visit?

I hereby give permission for examination and treatment.
I understand that I am responsible for all charges related to examination and treatment.

Patient's, Parent's or Guardian's Name _____ Date_____

Patient's Parent's or Guardian's Signature_____

For your convenience and safety, we use a computerized prescription program that will improve both the accuracy and convenience of prescribing your medications. *This program will allow for the electronic transmission of most of your prescriptions directly to your Pharmacy of choice and will eliminate your waiting time.* In most cases, it will also accommodate the transmissions of prescription to mail order pharmacies.

To use this new program, we need to collect some information from you on your pharmacy of choice. If you also have a mail order benefit program, please provide that information by selecting the appropriate box below.

Pharmacy Name _____

Street Name _____

City, Zip _____

Phone (_____) _____

INSURANCE CARRIER AGREEMENTS AND DISCLOSURES

INSURANCE AGREEMENT AND DISCLOSURE

PATIENT: _____

INSURANCE COMPANY: _____

I UNDERSTAND THAT ALL TREATMENT RENDERED TO ME WILL BE SUBMITTED TO MY INSURANCE COMPANY FOR PAYMENT. IF, AFTER MY INSURANCE COMPANY HAS BEEN BILLED IT IS DETERMINED THAT I HAVE NOT MET MY YEARLY DEDUCTIBLE AND/OR COPAYMENTS, I AGREE TO BE RESPONSIBLE FOR PAYMENT TO STACEY B. SCHWARTZ, DPM, PLC. ("MILLENNIUM FOOT AND ANKLE SPECIALISTS").

I UNDERSTAND AND ACCEPT THAT I AM RESPONSIBLE FOR PAYMENT TO STACEY B. SCHWARTZ, DPM, PLC, ("MILLENNIUM FOOT & ANKLE SPECIALISTS") OF ALL CHARGES SUBMITTED TO MY INSURANCE COMPANY FOR SERVICES PROVIDED, BUT DENIED FOR PAYMENT DUE TO SPECIFIC POLICY COVERAGE LIMITATIONS.

PATIENT OR AUTHORIZED
SIGNATURE: _____ DATE: _____

MEDICARE AND MEDI-GAP
INSURANCE AGREEMENT AND DISCLOSURE

PATIENT: _____

SECONDARY INSURANCE COMPANY: _____

I UNDERSTAND THAT ALL TREATMENT RENDERED TO ME WILL BE FIRST SUBMITTED TO MEDICARE AND THEN TO MY MEDI-GAP OR SECONDARY INSURANCE COMPANY. IF, AFTER MEDICARE AND MY SECONDARY INSURANCE COMPANY HAVE BEEN BILLED, IT IS DETERMINED THAT I HAVE NOT MET MY YEARLY DEDUCTIBLE AND/OR POLICY COPAYMENTS, OR IF FOR ANY OTHER REASON MY SECONDARY HEALTH INSURER DOES NOT PAY IN FULL, I AGREE TO RESPONSIBILITY FOR PAYMENT OF THESE BALANCES TO STACEY B. SCHWARTZ, DPM, PLC ("MILLENNIUM FOOT AND ANKLE SPECIALISTS")

PATIENT OR AUTHORIZED
SIGNATURE: _____ DATE: _____.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

THE UNDERSIGNED PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE ("AGENT") OF THE PATIENT ACKNOWLEDGES THAT HE OR SHE PERSONALLY ACCEPTS THE **MILLENNIUM FOOT & ANKLE SPECIALISTS** NOTICE OF PRIVACY POLICIES ON THE DATE INDICATED BELOW.

X _____ DATE: _____
PATIENT'S SIGNATURE

PATIENT'S NAME _____

INFORMATION ABOUT "AGENT" (ATTACH APPROPRIATE DOCUMENTATION) _____

AGENT'S SIGNATURE _____

TITLE OR RELATIONSHIP TO PATIENT _____

PATIENT: _____ Date: _____
What is the reason for your visit:

_____

_____

Pain Numbness Weakness Swelling Stiffness Other _____
Right toes Right Foot Right Ankle Right lower leg
Left Toes Left foot Left Ankle Left lower leg
When does problem occur?

_____

_____

How long ago did problem start? ___ Days ___ Months ___ Years
NO injury. Onset was: Gradual Sudden When did it start? _____
Injury not related to work or automobile How did it happen? _____
Injury related to work Fall Lifting Twisting Crushing
Injury related to sport? Date of injury_____
NO injury, but related to work. About when problem begin? _____
Auto accident. Date of Accident _____ What happened? _____

Have you been seen in an emergency room or by other physician for this problem? **Y N**
When?
Have you had tests, x-rays or scans for this problem? **Y N** Where?: _____

On a scale of 1-10 (10 is the worst pain) ***how severe is the pain?*** 1 2 3 4 5 6 7 8 9 10

What is the **quality** ***of the pain?*** Sharp Dull Stabbing Throbbing Aching Burning
The pain is Constant Intermittent (comes & goes) Occasional
Does the pain wake you from sleep? **Y N** Does the pain keep you from sleeping? **Y N**

Since my pain started it is Getting better Getting worse Unchanged

What makes your symptoms **worse?** Standing Walking Lifting Exercise Lying in bed
Wearing shoes Removing shoes Bending Squatting Kneeling Stairs Sitting

Which makes your symptoms **better?** Rest Elevation Ice Heat Other _____
Have you used medication for this problem? **Y N** What medication have you used?

_____
Have you had any other treatments for this problem? Injection Brace or Cast Cane/crutches
Physical therapy
Current work Status? Occupation _____ Standing Job Sitting Job
Not employed Retired Regular work Light duty
Disabled due to this problem Disabled due unrelated problem
Last day of regular employment? _____

Hospitalization, Surgery or Illnesses related to this complaint? None
Please explain:

_____
Dr. Review _____ Date: _____

DR. STACEY SCHWARTZ
DR. PHILIP WATKINS

Diseases, Deformities & Injuries of the Foot and Ankle

32255 Northwestern Highway Suite 195
Farmington Hills Michigan 48034
Telephone (248) 419-3550 Facsimile (248) 419-3547

IN GENERAL, THE HIPAA PRIVACY RULE GIVES A PATIENT THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF THEIR HEALTH BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME.

PLEASE COMPLETE THE FOLLOWING:

I, _____, WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

☐ CELL PHONE ( ) _____
- ☐ OK TO LEAVE DETAILED MESSAGE
- ☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

☐ HOME PHONE( ) _____
- ☐ OK TO LEAVE DETAILED MESSAGE
- ☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

☐ WORK PHONE ( ) _____
- ☐ OK TO LEAVE DETAILED MESSAGE
- ☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

PREFERRED CONTACT METHOD FROM OUR OFFICE
☐ CELL PHONE ☐ HOME PHONE ☐ WORK PHONE

FOR WRITTEN COMMUNICATION FROM OUR OFFICE:

- ☐ OK TO MAIL TO MY HOME ADDRESS
- ☐ OK TO MAIL TO MY WORK ADDRESS
- ☐ OK TO FAX INFORMATION TO: ( ) _____
- ☐ OTHER METHOD, PLEASE SPECIFY _____

TO PROVIDE INFORMATION TO SPOUSES, SIGNIFICANT OTHERS, COMPANIONS, PARENTS/CHILDREN, OR GUARDIANS, WE MUST HAVE WRITTEN PERMISSION. PLEASE STATE TO WHOM WE MAY GIVE YOUR PERSONAL HEALTH INFORMATION.

IT IS OK TO SHARE MY PERSONAL INFORMATION WITH THE FOLLOWING PEOPLE:

_____, Spouse/Companion/Significant Other/Parent/Child/Guardian

_____, Spouse/Companion/Significant Other/Parent/Child/Guardian

SIGNATURE: _____ DATE: _____/_____/_____

PATIENT MEDICAL HISTORY

Patient: _____ Today's Date: _____

Primary Care Physician: _____ Last Visit to physician: _____

REVIEW OF SYSTEMS

General Symptoms

Have you been in good general health?	Y N
Unexplained fatigue or frequent headaches?	Y N
Unexplained weight gain or weight loss?	Y N

Eyes

Eye disease or injury?	Y N
Blurred or double vision?	Y N
Glaucoma or Macular Degeneration?	Y N

Ears, Nose or throat

Nose bleeds, persistent sore throats?	Y N
Hearing loss or ringing in ears?	Y N

Cardiovascular

Chest pain, irregular heart beat?	Y N
Shortness of Breath?	Y N
Swelling of hands, ankles or feet?	Y N
Recent cardiac event or heart attack?	Y N
High Blood pressure?	Y N
Circulation Problems?	Y N
Fainting?	Y N

Respiratory (Pulmonary)

Chronic or frequent coughs?	Y N
Wheezing or Bloody coughs?	Y N
Asthma?	Y N
Bronchitis?	Y N
Pneumonia?	Y N
Tuberculosis?	Y N
Emphysema?	Y N

Gastrointestinal (Stomach)

Changes in bowel habits?	Y N
Nausea or vomiting?	Y N
Rectal bleeding or blood in stool?	Y N
Abdominal pains?	Y N
Loss of appetite?	Y N
Stomach Ulcers?	Y N
Gall Stones? Y N	

Genitourinary

Frequent, painful or burning urination?	Y N
Blood in urine or dark urine?	Y N
Kidney stones or Kidney diseases?	Y N
Changes in bladder habits?	Y N
HIV or a sexually transmitted disease?	Y N
Jaundice, Hepatitis or Liver diseases?	Y N

Females: Approximate date of last menstrual period?

_____

Are your periods: regular irregular absent

Endocrine

Hormone problems?	Y N
Excessive thirst or urination?	Y N
Skin becoming more dry?	Y N
Change in hat, glove or shoe size?	Y N
Diabetes? Insulin or no insulin	Y N
Thyroid problems?	Y N
Scarlet fever or Mononucleosis?	Y N

Musculoskeletal

Surgery of Hip, Leg or Foot?	Y N
Joint pain, stiffness, or swelling?	Y N
Weakness of muscles or joints?	Y N
Muscle pain or cramping of legs or feet?	Y N
Cold hands or feet?	Y N
Arthritis?	Y N
Polio or Paralysis?	Y N
Unequal leg length?	Y N
Knee pain? Right or Left	Y N
Bunions?	Y N
Hammer toes?	Y N
Gout?	Y N

Integumentary

Rash or itching?	Y N
Changes in skin color or texture?	Y N
Recent appearance of non-healing sores?	Y N
Keloids or thickened scars?	Y N
New or spreading skin lesions?	Y N
New or enlarged varicose veins?	Y N
Toenail Problems?	Y N
Skin Problems?	Y N

Neurological

Frequent headaches?	Y N
Convulsions or seizures?	Y N
Numbness or tingling in hands, legs or feet?	Y N
Head injury, tremors or paralysis?	Y N
Memory loss, confusion or Alzheimer's disease	Y N
Depression, anxiety or insomnia?	Y N
Stroke? Year? _____	Y N

Hematological

Slow to heal after cuts or recurrent infections?	Y N
Bleeding or bruising tendency?	Y N
Transfusion?	Y N
Blood clots?	Y N
Enlarged glands?	Y N
Low Iron in blood or other Anemia's?	Y N
Blood Disorders?	Y N

Cancer

Have you had cancer?	Y N
IF YES, WHAT TYPE OF CANCER?_____	
Are you under treatment for cancer?	Y N

Allergic/Immunologic

History of allergic or adverse drug reaction? Y N

Penicillin Sulfa Aspirin Tylenol Ibuprofen Codeine

Other Medication_____

Food:_____

Materials: Latex metals Adhesive tape

Other Materials_____

Airborne: _____

Is there anything the doctors should be aware of_

Authorization and release To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform to doctor's office of any changes in my medical status or medication use.

I authorize Dr. Schwartz, Dr. Watkins or their healthcare staff to perform an evaluation and treatment as needed.

Patient or Authorized signature: _____

Date: _____

MEDICATION

Patient Name: _____ Birth date: _____/_____/_____ TODAY'S DATE: _____/_____/_____ ALERTS: _____	Allergies: (☐ No Known Drug Allergies) _____ _____ _____

DATE	MEDICATION	CONDITION