4330 East Grand River Avenue

Howell, MI 48843

Phone: (517) 885-3300

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TOTAL FOOT AND ANKLE

Dr. Douglas Stoinski, DPM

Patient Form

Patient Name: _____ **DOB:** _____

Address: _____

Zip Code:_____ City: _____ State:_____

Sex: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Cell Phone: _____ Home Phone: _____

Email _____

*May we contact you at the provided number/email ? Yes No

****Policy Holder:** [ ] Self [ ]Other:_____ Patient's Relation:_____

DOB of Policy Holder: _____

***Please allow a 24 hour notice for any cancellation or rescheduling of appointments to avoid a $25.00 cancellation fee.**

How did you hear about us? _____

Patient Signature: _____ **Date:**_____

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. Therefore, we urge you, as the patient, to check with your insurance company prior to any treatment or surgery. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, responsible for all costs incurred. Please remember your insurance policy is between you and your insurance company, and not with your insurance company and your doctor.

I acknowledge that a copy of the Notice of Privacy Practices is *hh*POSTED IN OFFICE LOBBY and that I have read (or have had the opportunity to read, if I so chose) and understand the notice.

I also hereby give permission to examine, perform diagnostic tests, and treat my foot condition medically, surgically, and/or orthopedically. I authorize the release of any medical information necessary to process this claim.

Signature Date

_____

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. Therefore, we urge you, as the patient, to check with your insurance company prior to any treatment, visit, procedure or surgery. It is your responsibility to know your individual coverage, co-pays and deductibles. Failure to comply with this suggestion could result in you, the patient, responsible for all costs incurred. Please remember your insurance policy is between you and your insurance company, and not with your insurance company and your doctor or the medical staff.

Initial_____Date_____

Please allow a 24 hour notice for any cancellations or rescheduling of appointments to avoid a 25.00 fee.

Initial_____Date_____

Patient Medical History Checklist

Please check the appropriate box if you DO HAVE or HAVE HAD any of these conditions:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Blood Clot (Previous or Current)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Diabetes Type 11 or Type 1 **(please circle)**
- ☐ Dialysis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Other (Please Explain):
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Tuberculosis

Please list all medications: _____

_____

_____

Allergies (Medication/Other)_____

_____

Are you a: Non-Smoker ___ Former Smoker___ Current Smoker ___ (daily use_____)

Date of Last Flu Vaccine: _____

Date of Last Pneumonia vaccine: _____

Preferred Pharmacy (Name and Phone # or Address): _____

Primary Care Doctor: _____

Date last seen by your Primary Dr. _____

Name: _____

Signature: _____

Date: _____

If you are 65 y/o or older, do you have an Advanced Directive (Will or Power of Attorney): Y / N

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child _____

[ ] Other: _____

[ ] Information is not to be released to anyone.

TEXT MESSAGE /EMAIL APPOINTMENT REMINDER CONSENT

Name of Patient:	**Date of Birth:**
Parent/Guardian Name (if Patients under 18 years of age)	**Mobile Telephone and email**

As a courtesy to our patients, you have the option to receive automatic text message/email appointment reminders.

Please sign below if you would like to give consent and participate.

Patients Signature:_____ Date:_____ (Parent or guardian if under 18 years old)

We would like to invite you to our patient portal, let us know YES_____ or No not interested_____

****Please note this is a courtesy. We ask that you be aware of your appointment time and date and give us 24 hours' notice for changes or cancellations to avoid a $25.00 fee.**

ADVANCED BENEFICIARY NOTICE FOR NON COVERED SERVICES

Service /Supplies: Coverage is dependent upon each patient's individual insurance coverage.

We will do our best to inform you of uncovered charges that you may incur. By signing below you understand that it is not always possible to know what individual insurances cover.

I understand that I will be financially responsible for the cost if a claim is denied. I understand that I am responsible for all deductibles, co pays and coinsurances as well.

Total Foot and Ankle

Signature_____

Date_____

By signing below you area giving permission to receive automated text messages and or email appointment confirmation reminders from Total Foot and Ankle.

Signature_____Date_____

Phone_____Email_____