Dr. Alan L. Stiebel, D.P.M.
Dr. Brett W. Butler, D.P.M.

XRAY # _____
COMP # _____
DATE _____

PATIENT INFORMATION
PLEASE PRINT

LEGAL NAME _____
FIRST MIDDLE **LAST**

PHONE NUMBERS (_____) _____ (_____) _____ _____
CELL HOME E-MAIL

ADDRESS _____
STREET CITY STATE ZIP

MAILING ADDRESS _____
(if different than above) STREET CITY STATE ZIP

DATE OF BIRTH _____ AGE _____ PATIENT SOCIAL SECURITY NUMBER _____

EMERGENCY CONTACT _____
NAME PHONE NUMBER CELL NUMBER

PRIMARY PHYSICIAN _____

HOW DID YOU HEAR ABOUT OUR OFFICE? □ FRIEND _____ □ FAMILY _____

□ PHYSICIAN _____ □ INTERNET _____

□ SIGN □ OTHER _____

******** ALL INSURANCE INFORMATION MUST BE FILLED IN BY PATIENT OR LEGAL GUARDIAN ********

PRIMARY HEALTH INSURANCE _____

CARD HOLDERS NAME _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ CARD HOLDER DATE OF BIRTH _____

ID NUMBER _____ GROUP NUMBER _____SOCIAL SECURITY # _____

SECONDARY HEALTH INSURANCE _____

CARD HOLDERS NAME _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ CARD HOLDER DATE OF BIRTH _____

ID NUMBER _____ GROUP NUMBER _____SOCIAL SECURITY # _____

****** IF PATIENT IS A MINOR ******

NAME OF PARENT OR LEGAL GUARDIAN WHO BROUGHT THE MINOR IN _____

IS YOUR VISIT RELATED TO A WORK INJURY _____ OR AN AUTO INJURY _____ if so, please see receptionist for an additional form

INSURANCE AUTHORIZATION

Please accept this form as a request of payment made directly to Alan L. Stiebel, D.P.M and/or Brett W. Butler, D.P.M. for any services furnished me. Should there be any future questions regarding any claims, I authorize the release of any medical information to my insurance company and its agents needed to determine the benefits payable for related services.

Romeo Foot and Ankle Clinic will complete insurance forms and send them in on my behalf. The Romeo Foot and Ankle Clinic is the main billing office for both doctors. I will be responsible for payment of any balances not covered by my insurance company, including deductible and copayments. Payment for services not covered will be made in a timely manner or finance charges will be accessed. These may include by not be limited to rebilling charges.

I hereby give my permission to Dr. Alan L. Stiebel and Dr. Brett W. Butler and/or such associates and assistants who may participate with them to examine and treat my feet and/or ankle.

PATIENT NAME _____ DATE _____

SIGNATURE _____ DATE _____
PATIENT OR LEGAL GUARDIAN

********** IF THE PATIENT IS YOUNGER THAN 18 YEARS OLD, A PARENT OR GUARDIAN MUST SIGN AND AUTHORIZE TREATMENT **********

MEDICARE BENEFITS ONLY

I request payment of authorized Medicare Benefits be made to Alan L. Stiebel, D.P.M. and/or Brett W. Butler, D.P.M. for any services furnished me. I authorize the release of any medical information to the Healthcare Financing Administration and its agents needed to determine the benefits payable for related services.

PATIENT NAME _____ DATE _____

SIGNATURE _____ DATE _____

UNINSURED PATIENTS

I will be personally responsible for fully payment of medical care at the time service is rendered.

PATIENT NAME _____ DATE _____

SIGNATURE _____ DATE _____
PATIENT OR LEGAL GUARDIAN

OFFICE NAME AND PHONE NUMBER

ROMEO FOOT AND ANKLE CLINIC
ALAN L. STIEBEL, D.P.M.
BRETT W. BUTLER, D.P.M.
(586) 752-3519

MACOMB FOOT AND ANKLE SPECIALIST
ALAN L. STIEBEL, D.P.M.
BRETT W. BUTLER, D.P.M.
(586) 247-2050

PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME _____

DATE _____

XRAY # _____

WHAT PROBLEMS ARE YOU HAVING WITH YOUR FOOT/ANKLE?

_____

_____

Duration _____ Is this a work or auto accident related injury? ____ Yes ____ No

Shoe Size _____ Regular type of shoe _____ Height _____ Weight _____

Occupation _____ Numbers of hours on feet for a workday _____ Surface standing on _____

Age _____ Marital Status _____

ALLERGIES (Please check an of the following that may apply)

____ Latex ____ Penicillin ____ Novocain ____ Codeine ____ Adhesives

____ Iodine ____ Aspirin ____ Antihistamines ____ Sulfa Other _____

____ Nylon ____ Tetanus ____ Anesthetics ____ Darvon Other _____

____ Plastics ____ Demerol ____ Merthiolate ____ Shellfish Other _____

Reaction _____

CURRENT MEDICATIONS (Including Inhalers, Patches, Vitamins and Herbal Preparations)

DRUG NAME	AMOUNT OF DOSAGE	TIMES PER DAY	REASON

PAST SURGERIES/OPERATIONS

DATE	TYPE OF SURGERY/OPERATION

SENSORY / INTEGUMENTARY

- Have you ever had any eye problems? __ No __ Yes Describe _____
- Do you have any problems with your hearing? __ No __ Yes Right / Left / Both
- Do you have any skin problems? __ No __ Yes Eczema Acne Psoriasis Rash circle all that apply

SOCIAL

- Do you drink alcoholic beverages? __ No __ Yes How many? _____ How often? _____
- Have you had a problem with alcohol abuse? __ No __ Yes Describe _____
- Are you currently a smoker? __ No __ Yes Packs per day _____ How long _____
- Have you quit smoking? __ No __ Yes When _____ How long ago did you smoke _____

MUSCULOSKELETAL

- Do you have any physical disabilities? __ No __ Yes Describe _____
- Have you been diagnosed with arthritis? __ No __ Yes Describe _____
- Have you been diagnosed with muscle problems? __ No __ Yes Describe _____
- Do you have any back or neck problems? __ No __ Yes Describe _____

GASTROINTESTINAL

- Do you have any bowel problems? __ No __ Yes Describe _____
- Have you had a significant weight loss in the past Four months without trying to diet? __ No __ Yes How much _____
- Do you have nausea, vomiting or frequent heartburn after eating? (circle any that apply) __ No __ Yes
- Have you even been diagnosed with reflux or a hiatal hernia? __ No __ Yes
- Have you ever had mononucleosis, hepatitis or cirrhosis? __ No __ Yes Describe_____

CARDIO / NUERO / VASCULAR

- Have you ever had a heart attack? __ No __ Yes When _____
- Have you ever been diagnosed with angina or pain in the chest related to your heart? __ No __ Yes When _____
- Have you ever been treated for high blood pressure? __ No __ Yes
- Do you have a heart murmur or Mitral Valve Prolapse? __ No __ Yes
- Have you been diagnosed with an irregular or fast heartbeat? __ No __ Yes When _____
- Have you ever had fluid in the lungs related to heart failure? __ No __ Yes When _____
- Have you ever had phlebitis or blood clots? __ No __ Yes When _____ Area _____
- Have you ever had a stroke/Parkinson's Disease or tremors? __ No __ Yes When _____
- Describe any leftover effects (i.e. paralysis) _____
- Do you have frequent headaches? __ No __ Yes Describe _____
- Have you ever had epilepsy or seizures? __ No __ Yes Date of last seizure _____

RESPIRATORY

- Do you have any difficulties with breathing or wheezing __ No __ Yes Describe _____
- Have you ever been diagnosed with asthma? __ No __ Yes When _____
- Have you ever been diagnosed with emphysema? __ No __ Yes When _____
- Have you ever been diagnosed with hay fever, allergies, or sinus problems? __ No __ Yes When _____
- Do you get short of breath walking up one flight of stairs? __ No __ Yes
- Do you CURRENTLY have a cough/cold/sore throat or flu __ No __ Yes Describe _____
- Have you ever had an abnormal chest X-Ray? __ No __ Yes When/Results _____

ENDOCRINE / HEMETOLOGIC / GENITOURINARY

- Do you have diabetes? __ No __ Yes How long _____
- Have you ever been diagnosed with hypoglycemia? __ No __ Yes When _____
- Are you on a special diet now? __ No __ Yes Describe _____
- Have you ever had thyroid problems or a goiter? __ No __ Yes Describe/When _____
- Do you bleed or bruise easily? __ No __ Yes
- Have you had a blood transfusion in the last 3 months? __ No __ Yes
- Have you ever been diagnosed with anemia, Sickle Cell Anemia or any other blood or bleeding disorder? __ No __ Yes Describe/When _____
- Have you ever had any kidney or bladder problems? __ No __ Yes Describe/When _____
- FEMALES: Are you or could you be pregnant? __ No __ Yes

MISCELLANEOUS / OTHER

- Have you ever been diagnosed with cancer? __ No __ Yes Describe/When _____
- Have you had any illness/disease not mentioned above? __ No __ Yes Describe/When _____

ADDITIONAL COMMENTS: