ANKLE & FOOT
CARE SPECIALISTS, PLLC

WELCOME TO ANKLE & FOOT CARE SPECIALISTS, PLLC

Excellence in Comprehensive & Compassionate Care

PLEASE COMPLETE INFORMATION COMPLETELY. PLEASE PRESENT PHOTO ID AND INSURANCE CARDS. THANK YOU! ☺

Patient Name_____SSN:_____-_____-_____DOB:_____

Address:_____City:_____Zip:_____

Phone:_____Cell:_____**Email:**_____

Employer:_____Occupation:_____

Marital Status: (circle one) Single Married Divorced Widow Minor

Whom may we thank for this referral?:_____

Primary Care Physician:_____Phone:_____

Emergency Contact:_____Relationship:_____

Phone:_____

Insurance Information:

Primary Insurance:_____Subscriber:_____

Subscriber DOB:_____

Secondary Insurance:_____Subscriber:_____

Subscriber DOB:_____

ASSIGNMENT AND RELEASE (ALL INSURANCES EXCEPT MEDICARE):

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Mansour all insurance benefits, if any, otherwise payable to me for services 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature *Relationship* *Date*

MEDICARE AUTHORIZATION:

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Mansour for services furnished to me by the 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 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, or elsewhere on other approved claim forms or electronically submitted claims, my signature below authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Responsible Party Signature Relationship Date

Cancellation Policy

Please be courteous, if you are unable to attend your scheduled appointment; kindly give us **24 hours notice**. If you fail to show for your scheduled appointment, you will be charged a **35.00 fee**.

My signature below confirms my acknowledgment of this policy.

_____

Signature **Date**

Privacy Practices Acknowledgement

Your personal information will only be provided to:

- Your insurance company
- Your primary care physician
- Any specialists that you have been referred to by our office
- Any tests that we schedule for you

This will only be done as necessary.

Name:_____

Signature:_____ Date:_____

Ankle & Foot Care Specialists, PLLC
Excellence in Comprehensive & Compassionate Care

17940 Farmington Road Suite 110
Livonia, MI 48152
Telephone: **734-744-5661** Fax: 248-888-9504

DR. ISSAM N. MANSOUR
Associate American Board of Podiatric Surgery
Associate American College of Foot & Ankle Surgeons

NAME:_____ **SSN:** ___ - ___ - ____ **DATE:**_____

MEDICAL HISTORY *Please fill out to the best of your knowledge.*

FAMILY PHYSICIAN: _____ PHONE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

DATE LAST SEEN: _____ FORMER PODIATRIST: _____

WHY DID YOU SEE YOUR FORMER PODIATRIST? _____

WHAT PROBLEMS BRING YOU TO OUR OFFICE? _____

_____

PLEASE LIST ALL MEDICATIONS AND DOSAGES WHICH YOU NOW USE (PLEASE INCLUDE OVER THE COUNTER)

_____

_____

HEIGHT: _____ WEIGHT: _____ AGE: _____ MALE ☐ FEMALE ☐

FOR WOMEN ONLY: ARE YOU PREGNANT? _____ IF SO, HOW MANY MONTHS? _____

INDICATE WHICH OF YOUR IMMEDIATE RELATIVES HAVE HAD ANY OF THE FOLLOWING DISEASES:

CANCER: _____ DIABETES: _____

HEART TROUBLE: _____ HIGH BLOOD PRESSURE: _____

KIDNEY DISEASE: _____ MENTAL/EMOTIONAL DISEASE: _____

STROKE: _____ ARTHRITIS: _____

SMOKING HISTORY: -------- NEVER SMOKER ------- FORMER SMOKER ------ CURRENT EVERY DAY SMOKER

PLEASE CHECK **"YES" OR "NO"** TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS:

YES	NO	NATURE OF PROBLEM	COMMENTS AND GIVE APPROXIMATE DATE
		RECENT WEIGHT LOSS	
		HEADACHES	
		TROUBLE WITH VISION	
		TROUBLE WITH HEARING	
		ALLERGIES/HAY FEVER	
		ASTHMA	
		ALLERGIES TO FAKE METALS OR JEWLERY	
		ALLERGIC REACTIONS TO MEDICATION	
		THYROID	
		DIABETES	
		SKIN	
		ANEMIA	
		HEART	
		MITRAL VALVE PROLAPSE/HEART MURMUR	
		CIRCULATION	
		DO YOU HAVE A PACEMAKER	
		HIGH BLOOD PRESSURE	
		CHEST PAIN	
		LUNGS (PNEUMONIA, TB, ETC.)	
		SHORTNESS OF BREATH (COUGH, PLEURISY, WHEEZING)	
		LIVER DISEASE, GALL BLADDER DISEASE (OR JAUNDICE)	
		STOMACH TROUBLE	
		SWELLING IN FEET OR ANKLES	
		ARTHRITIS	
		KIDNEY DISEASE OR STONES	
		GOUT	
		BLEEDING TENDENCY	
		SCARRING TENDENCY	
		JOINT PAIN OR STIFFNESS	
		NUMBNESS IN FEET OR LEGS	
		CRAMPS IN FEET OR LEGS	
		LOWER BACK PAIN	
		DO YOU SMOKE? HOW MUCH?	
		DO YOU DRINK ALCOHOL? HOW MUCH?	
		DO YOU TAKE ANY DRUGS: (LEGAL OR ILLEGAL?) How much?	
		PSYCHIATRIC	
		FAINTING OR CONVULSIONS	
		STROKES	
		PAIN IN OTHER AREA'S	
		OTHER ILLNESSES OR PROBLEMS	
		HIV POSITIVE	

PLEASE GIVE DETAILS IF ANY:
OPERATIONS/SERIOUS INJURIES APPROXIMATE DATE PHYSICIAN HOSPITAL

_____

_____

HAVE YOU HAD ANY PHYSICAL THEARAPY? WHEN? FOR WHAT CONDITION?_____

IS THERE ANYTHING YOU WISH TO TELL YOUR PHYSICIAN PRIVATELY? YES____ NO _____

*I HEREBY GIVE PERMISSION TO **DR. ISSAM N. MANSOUR** TO EXAMINE, PERFORM DIAGNOSTICS AND TREAT MY FEET/ANKLES MEDICALLY, SURGICALLY OR ORTHOPEDICALLY.*

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____