Carroll
Foot & Ankle

Dr. Victoria Carroll
Dr. Joshua Carroll
6080 Dixie Highway • Suite C • Clarkston, Mi, 48346
Phone (248) 602-3501 • Fax (248) 602-3502

Patient Fact Sheet

This information is strictly confidential

Today's Date: _____

Name: _____ Date of Birth: _____
(Last) (First) (Middle)

☐Male ☐Female SS#: _____

If patient is a minor, name of responsible adult: _____

Home Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: Cell Phone: _____

Work Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

☐Single ☐Married ☐Widow(er) ☐Partner ☐Divorced

Spouse: _____ Date of Birth: _____
(Last) (First) (Middle)

Spouse Primary Phone: _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Pharmacy: _____
(Name) (Location)

How did you hear about our office? _____

ALL CHARGES FOR SERVICES ARE THE RESPONSIBILITY OF THE PATIENT

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 policyholder, to please 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, being responsible for all costs incurred. Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

A **$45 fee** will be charged for cancelled or missed appointments without twenty-four hour advance notice. Should the account be referred to a collection agency, the patient shall pay collection expense and attorney's fees if applicable.

Language: _____ Race: _____ Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Patient signature: _____ Date: _____
(Signature of Parent or Legal Guardian if patient is a minor or incompetent to give consent)

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Patient Medical History

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____
Height: Weight: _____ Shoe Size: _____ Age: _____

What is your foot/ankle problem?

When did you first notice the problem?

Have you ever been treated for this? (When/Where)

Are you diabetic? _____ If yes, controlled by: □Diet □Insulin □Medication:_____
Please list medications and dosage: _____

Allergies and Reaction: (Please check all that apply)

□Aspirin □Bactrim □Codeine □Iodine □Novocain □Demerol
□Penicillin □Sulfa □Adhesive Tape □Latex □Antihistamines □Food □Other: _____

Medical history: (Please check all that apply)

□Anemia	□Arteriosclerosis	□Arthritis	□Asthma	□Bleeding Tendencies
□Cancer	□COPD	□Diabetes	□Epilepsy	□Eye Problems
□Gout	□Heart disease	□Hepatitis	□High Blood Pressure	□High Cholesterol
□HIV/AIDS	□Kidney disease	□Numbness	□Polio	□Rheumatic Fever
□Scarlet fever	□Heart Stent	□Stomach Ulcers	□Stroke	□Tuberculosis
□Tumors	□TBI	□Currently Pregnant	□Currently Breastfeeding	□GERD

Surgical History: _____

Do you smoke? □Yes □No ___pack/day x ___ years. Quit, but I smoked ___ pack/day x years.
Do you drink alcohol? □Yes □No How often? _____ Recreational Drugs? □Yes □No

Is th ere anything else we should know? _____
___

I hereby authorize Joshua Carroll D.P.M. and Victoria Carroll D.P.M. to examine, perform diagnostic tests, and treat my feet medically, surgically, and or orthopedically. I also authorize the release of any medical information necessary to process this claim. All benefits are to be paid to the above named physicians for any services rendered.

Patient signature: _____ Date: _____ ___
(Signature of Parent or Legal Guardian if patient is a minor or incompetent to give consent)

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Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Personal History: (Please check all that apply)

	Yes	No
Bunion/HAV		
Thick Nails		
Dizziness		
Peripheral Vascular Disease		
Swelling of Feet Extremities Cold		
Stroke or CVA Varicose Veins		
Persistent Cough		
Tuberculosis Shortness of Breath		
Athletes Foot		
Deformed Nails		
Ingrown Nail		
Wart		
Corns/Calluses Skin Cancers		
Ankle Pain		

	Yes	No
Broken Bones		
Hammer Toes		
Joint Stiffness		
Muscle Pain/Weakness		
Painful Toe(s) Arthritis Bursitis Foot Pain		
Heel Pain Low Back Pain Numbness		
Developmental Delay Dementia		
Anemia		
Bleeding Disorder Anxiety		
Depression		

Date of Last Mammogram: _____

Date of Last Influenza Vaccine: _____

Date of Last Colonoscopy: _____

Date of Last Pneumonia Vaccine: _____

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Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Family Medical History: (Please provide medical history for your mother OR father)

□ Adopted □ Unknown

Name: _____

Date of Birth: _____ Approximate Age: _____

Living: □ Yes □ No If no, cause of death: _____

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino

Race: □ American Indian or Alaska Native
□ Asian
□ Black or African American
□ White
□ Other: _____

Smoking Status:
□ Current
□ Former
□ Never
□ Unknown

Language: _____

Family History of:
□ Diabetes
□ Cancer
□ Heart Disease
□ Hypertension
□ Other: _____

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ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name _____ Date of Birth Today's Date

Parent of Authorized Representative (if applicable)

Signature

Notices of Privacy Practices is located behind this page. Copies are available at the desk.

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Patient Responsibility Form

I understand and agree that I am financially responsible for all charges for any and all services rendered.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage or insurance carrier. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. IT will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

If I am a Medicare Advantage patient, I understand that I need to provide the office with my Medicare Advantage card. If I present my Medicare card instead of my Medicare Advantage card, I will be responsible for non covered items or out-of-network fees.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, as required by law. I have the right to revoke this Consent, in writing, signed by myself. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. This form complies with the Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Name (Guardian Name if applicable) _____ **Date of Birth**

Patient or Guardian Signature _____ **Today's Date**