Personal Medical History
Barth Wolf DPM and Daniel Reznick DPM

Patient's Last Name _____ First _____ Middle Int. _____

Mailing address _____ City _____ State ____ Zip _____

Age _____ Sex _____ Social Security: _____ Date of birth _____ Marital Status_____

Home phone _____ Cell Phone _____ Work phone _____

Race: American Indian or Alaska native Asian Black or African American Native Hawaiian White

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Primary Insurance Company: _____ Policy Holder _____

Relationship to Patient: _____ Date of Birth _____

Secondary Insurance Company _____ Policy Holder _____

Relationship to Patient: _____ Date of Birth _____

If someone (other than the patient) is responsible for the patient's bill, please complete the following:

Responsible party Name: _____ Phone _____

Address _____ City _____ State _____ Zip _____

How did you learn of our office? Phone book Insurance Internet Friend/family Drive by Advertisement Doctor
Other _____

Who is your primary or referring doctor? _____

Address _____ City _____ State _____ Zip _____

Employment: Occupation: _____

Main activity includes (please circle) Sitting Standing Walking Lifting

The work place floor is: (please circle) Concrete Carpet Rubber mat Other: _____

Reznick, Wolf Podiatry and Associates
Medical information form

Name_____

Describe your foot problem (Give specific location) _____

_____

_____

How long has this been bothering you? _____ days _____ weeks _____ months _____ years

Please circle what you feel. You may circle more than one:

Burning Throbbing Sharp Dull Aching Numbness Tingling Shooting

How intense is your pain? 0= none, 10= severe (circle one) 1 2 3 4 5 6 7 8 9 10

What causes the problem or makes it worse? _____

Are there any other problems associated with your foot complaint? (e.g.; back or leg pain) _____

_____

List previous and current treatments for this condition _____

_____

Do you have any other foot problems that need attention? _____

_____

Is this a work injury? Yes No Auto Accident? Yes No Other _____

ALLERGIES Please check those that apply: ____ No known drug allergies

____ Erythromycin ____ Aspirin _____ Metals _____ Latex _____ Codeine

____ Iodine / dyes ____ Sulfa drugs _____ Morphine _____ Penicillin

_____ Foods _____ _____ Other _____

MEDICATIONS (List all medications you take regularly. Include over the counter or non- prescription medications. Please include the dose. If you have a list we would be happy to make a copy.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Reznick, Wolf Podiatry and Associates
Medical information form

HAVE YOU EVER HAD THE FOLLOWING ILLNESSES (CHECK THOSE THAT APPLY)

MAJOR DISEASE:

___ Diabetes
___ High blood pressure
___ Angina (chest pain)
___ Heart Disease
___ Other _____

___ Heart Attack
___ Arrhythmia
___ Murmur
___ Mitral Valve Prolapse
___ Stroke
___ Chest Pain

RESPIRATORY:

___ Asthma
___ Emphysema
___ Shortness of Breath

ARTHRITIS:

___ Osteoarthritis
___ Rheumatoid
___ Gout
___ Fibromyalgia
___ Other _____

VASCULAR:

___ Anemia
___ Sickle Cell
___ Bleeding Disorder
___ Poor Circulation
___ Blood Clots

GASTROINTESTINAL:

___ GI or Rectal Bleeding
___ Stomach Problems
___ Hiatal Hernia

MISCELLANEOUS:

___ Epilepsy
___ Thyroid Disease
___ Muscle Disease
___ Kidney Disease
Other _____

___ Bladder Problem
___ Prostate Problems
___ Venereal Disease
___ Skin Conditions
___ Cancer; type _____
___ Hepatitis

___ Bowel Disorders
___ Ulcers
___ Acid Reflux

SURGICAL HISTORY: Please list all past operations on any part of your body. (Give dates)

_____

_____

_____

Do you have any artificial joints? Yes No Do you have heart valve implant? Yes No

Do you have mitral valve prolapse? Yes No

FAMILY HISTORY

(CHECK THOSE THAT APPLY for Father (F) and or Mother (M).

__ Diabetes (F) (M)
__ Rheumatoid Arthritis (F) (M)

__ Kidney Disorder (F) (M)
__ Respiratory Disease (F) (M)

__ Seizures (F) (M)
__ Osteoarthritis (F) (M)

___ Cancer (F) (M)
___ High blood pressure (F) (M)

___ Bleeding Tendencies (F) (M)
___ Nervous Disorder (F) (M)

___ Liver Disorder (F) (M)
___ Gout (F) (M)

___ Heart Disease (F) (M)
___ Thyroid problems (F) (M)

___ Asthma (F) (M)
___ Stroke (F) (M)

___ Anemia (F) (M)
___ Sickle Cell Anemia (F) (M)

Reznick, Wolf Podiatry and Associates
Medical information form

SOCIAL HISTORY

Employment: (Y) (N) Occupation:_____

Smoker: (Y) (N) If yes about how many packs per day _____ How many years: _____
Former smoker: (Y) (N) How many years ago: _____

Drink alcoholic beverages (Y) (N) If yes, amount per week: _____

Review of Symptoms: (circle all that apply or circle None)

Constitutional: None, Weight loss, Weight gain, Fever or chills, Trouble sleeping, Fatigue, Weakness

Eyes: None, Vision loss, Glasses or contacts, Double vision, Tearing, Itchy, trauma

ENMT: None, Headache, Head injury, Decreased hearing, Ear ache, Ringing in ears (tinnitus), Drainage, Nose bleeds, Cough, Sore Throat (longer than 1 week)

Skin: None, Dry skin, Rash, Ulcer, Eczema, Psoriasis, itchy skin, hyperhydrosis (sweat a lot) Blister

Muscle Skeletal: None, Foot pain, Joint pain, Neck pain, back pain, hip pain, knee pain morning stiffness, Weakness

Neurological: None, Numbness, burning, hypersensitive, seizure, uncontrolled movements, tremors, trauma

Urinary: None, Burning urination, dialysis, Frequent urination, Infrequent urination

Endocrine: None, hyperglycemia, hypoglycemia, Frequent thirst, fatigue

Respiratory: None, Asthma, shortness of breath, snoring, cough, chest pain, Chest tightness, Wheezing

Gastric: None, Acid Reflux / heart burn, Abdomen Pain, Blood in Stool, Constipation, Diarrhea, hemorrhoids, Vomiting

Cardiovascular: None Chest pain or discomfort Tightness Shortness of breath

Psychiatric: None depression paranoia addictive tendencies irritability

Fall Assessment: Have you had 2 or more falls in the past year? Yes No

Financial Responsibility and Policy Sheet
Reznick, Wolf and Associates PC
Chelsea Podiatry

Printed Patient Name: _____

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following polices.

INSURANCE: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment/deductibles. However, **This office's policy is to collect this co-payment/deductibles in FULL the day of your appointment. This means: If you only have MEDICARE and NO secondary insurance or Medicaid as your secondary (which we do not take) the percentage which they do not cover will be your responsibility. This is all billable services, including Durable Medical Equipment and Orthotics. This will be collected at the front desk at the time of your visit.**

It is up to YOU to know your deductibles and co-pays. YOU need to know what is a covered benefit.

Miscellaneous:

You acknowledge that the insurance card and information provided each visit is the correct and current information. You understand that it is your responsibility to inform our office if a change in your insurance coverage occurs.

In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. If your treatment requires surgery performed at the hospital, we will bill your health plan for all our services provided in the hospital. You understand that these physician fees are separate than surgical assists, hospital anesthesia, and lab or pathology fees.

Uninsured patients: As a private pay patient you will be asked to pay your balance IN FULL at the time of service.

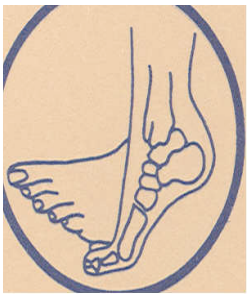
Assignment of Benefits: I hereby assign all medical and surgical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to the office of Reznick Wolf and Associates, P.C., doctors Barth Wolf and Daniel Reznick, for medical services rendered to myself and/or my dependents regardless of insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I have requested medical services from the Podiatry office of Reznick, Wolf and Associates, P.C., on behalf of myself and/or my dependents. I understand by making this request, I become fully responsible for any and all charges incurred during the course of treatment. In the event of default, I understand that the office of Reznick, Wolf and Associates, P.C. may use an outside collection company.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately at the front desk.

_____

Patients Signature (required)



Barth A Wolf DPM & Daniel F Reznick DPM

Podiatry Offices

Board Certified Foot and Ankle Care

Chelsea Podiatry
1200 South Main Street
Chelsea MI 48118
734 475-1200
734 475-9210 (fax)

Authorization for Record release and Payment

1. Authorization for Release of patient Records

   I, _____, Authorize Reznick, Wolf and Associates, P.C. to release information contained in my patient records to the referring physician identified in my Patient Information form and/or to any other physician or health care professional/entity to whom I may be referred to by Reznick, Wolf and Associates, P.C.

2. I was given the opportunity to read the office **Notice of Privacy Practices.** I understand my rights to access my medical records, disclosure of my personal information and that I have a right to request an amendment to my health information. I realize I am entitled a copy of their **Notice of Privacy Practices** if I so choose.

3. Authorization for Payment

   I Authorize the release of any protected health information (PHI) necessary to process claims for payment. I hereby authorize payment of insurance benefits, including Medicare benefits, to be made directly to Reznick, Wolf and Associates, P.C. I understand that I am financially responsible to Reznick, Wolf and Associates, P.C. for services not covered or payable by my insurance carrier.

4. Lifetime Medicare Authorization

   I request that payment of authorized Medicare benefits be made either to me or on my behalf to Reznick, Wolf and Associates, P.C. or its agent, for any services furnished to me by that supplier. I authorize any holder of hospital or medical information about me to release to the Social Security Administration Centers for Medicare, or its intermediaries or carriers any information of documentation needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand Reznick, Wolf and Associates, P.C. may use this authorization for all services in the future until such time as I revoke this authorization in writing. (Section 1128B of the Social Security Act and 31 U.S.C. 381-3812 provides penalties for withholding this information).

_____ _____
Patient Name Date

_____ _____ _____
Parent or Guardian Relationship to patient Date