

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

XRAY# _____
COMP# _____
DATE _____

PATIENT INFORMATION
PLEASE PRINT

LEGAL NAME _____ MALE _____ FEMALE _____
First Middle Initial Last
PHONE NUMBERS (____) _____ (____) _____ (____) _____
Home Cell/Beeper Work
ADDRESS _____
Street City State Zip
MAILING ADDRESS (if different) _____
P.O. Box City State Zip
DATE OF BIRTH _____ AGE _____
PATIENT'S SOCIAL SECURITY NUMBER _____
EMPLOYER _____
PERSON TO CONTACT IN CASE OF EMERGENCY _____
THEIR PHONE NUMBER _____ CELL/BEEPER _____
YOUR PRIMARY PHYSICIAN NAME _____
ADDRESS _____ PHONE _____
HOW DID YOU HEAR ABOUT OUR OFFICE? _____

****ALL INSURANCE INFORMATION MUST BE FILLED IN BY PATIENT****

PRIMARY HEALTH INSURANCE COMPANY _____
CARD HOLDERS NAME _____ RELATIONSHIP TO PATIENT _____
EMPLOYER _____ CARDHOLDER DATE OF BIRTH _____
I.D. NUMBER _____
GROUP NUMBER _____ SOCIAL SECURITY # _____

SECONDARY HEALTH INSURANCE COMPANY _____
CARD HOLDERS NAME _____ RELATIONSHIP TO PATIENT _____
EMPLOYER _____ CARDHOLDER DATE OF BIRTH _____
I.D. NUMBER _____
GROUP NUMBER _____ SOCIAL SECURITY# _____

PRINTED NAME OF PARENT OR LEGAL GUARDIAN WHO BROUGHT MINOR IN _____
IS YOUR VISIT RELATED TO A WORK INJURY _____ OR AUTO INJURY _____
IF SO, PLEASE SEE RECEPTIONIST FOR ANOTHER 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. and/or Hengelberth D. Montufar, 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 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 financial charges will be accessed. These may include but not be limited to rebilling charges.

I hereby give my permission to Dr. Alan L. Stiebel, Dr. Brett W. Butler, Dr. Hengelberth Montufar, D.P.M. and/or such associates and assistants who may participate with them to examine and treat my feet and/or ankles.

PRINT NAME _____ Date _____

SIGNATURE _____ Date _____
Patient or Guardian’s Signature

For patients less than 18 years old, a parent or guardian must sign and authorize treatment.

FOR MEDICAL 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., Dr. Hengelberth Montufar, 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.

PRINT NAME _____ Date _____

SIGNATURE _____ Date _____
Patient or Guardian’s Signature

FOR PATIENT WITH NO INSURANCE

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

PRINT NAME _____ Date _____

SIGNATURE _____ Date _____
Patient or Guardian’s Signature

Romeo Foot and Ankle Clinic
Alan L. Stiebel, D.P.M.
Brett W. Butler, D.P.M.
Hengelberth D. Montufar, D.P.M.
(586)752-3519

Macomb Foot and Ankle Specialist
Alan L. Stiebel, D.P.M.
Brett W. Butler, D.P.M.
Hengelberth D. Montufar, D.P.M.
(586)247-2050

Richmond Foot and Ankle
Hengelberth D. Montufar, D.P.M.
(586)727-7867

PATIENT MEDICAL HISTORY QUESTIONNAIRE

WHAT PROBLEMS ARE YOU HAVING WITH YOUR FOOT/ANKLE?

Name _____
Xray # _____

Duration _____ Related to a work or auto injury? Yes No
 Shoe Size _____ Regular shoe type _____ Height _____ Weight _____
 Occupation _____ Number of hours on feet for workday _____ Surface standing on _____
 Age _____ Marital Status _____

ALLERGIES (Please check any of the following that you are allergic to.)

____ 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	OF TIME PER DAY	REASON

PAST SURGERIES/OPERATIONS NONE

DATE	NAME OF OPERATION

SENSORY INTEGUMENTARY

Have you ever had any eye problems? No Yes Describe _____
 Do you have any problem with your hearing? No Yes Right/Left/Both No Yes Right/Left
 Do you have any skin problems? No Yes Circle all that apply (eczema
 Acne, psoriasis, rash)

SOCIAL

Do you drink alcoholic beverages? No Yes How many _____ How often _____
 Have you ever had a problem with alcohol abuse? No Yes Describe _____
 Are you currently a smoker? No Yes Packs per day _____ Years _____
 Have you quit smoking in the past? When? _____ No Yes How many years did you smoke? _____

MUSCULOSKELETAL

Do you have any physical disabilities? No Yes Describe _____
 Are you been diagnosed with arthritis? No Yes Describe _____
 Are 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 all that apply) No Yes
- Have you ever been diagnosed with reflux or a hiatal hernia? No Yes
- Have you ever had mononucleosis, hepatitis or cirrhosis? No Yes Describe _____

CARDIO/NEURO/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
- 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 ever been diagnosed with an irregular or fast heart beat? 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, sinus problems? No Yes When it start? _____
- Do you get short of breath walking up one flight? 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/HEMATOLOGIC/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 When/Describe _____
- Do you bleed or bruise easily? No Yes
- Have you had a blood transfusion in the last 3months? No Yes
- Have you ever been diagnosed with anemia, Sickle Cell Anemia or any other blood or bleeding disorder? No Yes Describe _____
- Have you ever had any kidney or bladder problems? No Yes Describe _____
- Females? Could you be pregnant? No Yes

MISCELLANEOUS/OTHER

- Have you ever been diagnosed with Cancer? No Yes When/Describe _____
- Have you had any illness/disease not mentioned above? No Yes When/Describe _____
- Additional Comments: _____