# WELCOME TO THE OFFICE OF STEPHANIE CAROLLO, DPM

48467 Van Dyke Ave
Shelby Twp., MI 48317
Phone: (586) 298-1585 / Fax: (586) 298-1591

**CONTACT INFORMATION:**

Patient Name: ______________________ DOB: ______________ Age: ________

Address: ______________________________________________

City: ______________________ State: __________ Zip Code: __________

Cell Phone: ______________ Home: ______________ Work: ______________

Okay to receive appointment reminders via cell (text message) or home phone: Yes No
Email Address: ______________________________________________
(Please note: We will not share your email address.)

Social Security # (If minor, please provide parent's): ______________________

Marital Status (circle one): S M W D Prefer not to specify

Emergency Contact Name: ______________________ Phone: ______________

Family Physician/Internist: ______________________ Phone: ______________

Pharmacy: ______________________ Phone: ______________

Whom may we thank for referring you to our office? ______________________

**INSURANCE INFORMATION:**

Insurance Company Name: ______________________________________________

Insurance Subscriber's Name: ______________________ Subscriber's DOB: ______________

Secondary Insurance: ______________ Subscriber Name & DOB: ______________

Responsible Party's Name & DOB (if other than patient): ______________________

Responsible Party's Address (if different than patient's): ______________________

Do you have an HMO insurance (circle one): *YES NO
*If yes, you must have your referral with you at the time of your appointment or the appointment will have to be rescheduled.

**MEDICAL HISTORY:**

| Condition | | | Condition | | | Condition | | |
|---|---|---|---|---|---|---|---|---|
| Anemia | Y | N | Congestive Heart Failure | Y | N | Liver disease | Y | N |
| Asthma | Y | N | Diabetes | Y | N | Scoliosis | Y | N |
| Arthritis (rheumatoid) | Y | N | Fibromyalgia | Y | N | Stomach/intestinal ulcer/bleed | Y | N |
| Arthritis (osteo) | Y | N | Heart attack | Y | N | Stroke | Y | N |
| Blood clots | Y | N | Heart disease/CAD | Y | N | Thyroid problem | Y | N |
| Blood transfusion | Y | N | Hepatitis A/B/C | Y | N | Tuberculosis | Y | N |
| Cancer | Y | N | High blood pressure | Y | N | Ulcers (Foot or skin) | Y | N |
| Cholesterol | Y | N | Kidney disease | Y | N | | | |

DO YOU HAVE ANY MEDICAL PROBLEMS NOT LISTED ABOVE? ______________________

Do you currently have any problems related to the following systems? Circle Y or N. If you haven't seen a physician for these symptom(s) yet, please contact your PCP/primary care physician to address these issues.

**Constitutional Systems**

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Excessive fatigue | Y | N |

**Musculoskeletal**

| | | |
|---|---|---|
| back pain | Y | N |
| hip pain | Y | N |
| knee pain | Y | N |

**Hematological/Lymphatic**

| | | |
|---|---|---|
| Blood clotting problem | Y | N |
| Swollen glands | Y | N |

**Psychological**

| | | |
|---|---|---|
| anxiety | Y | N |
| depression | Y | N |

**Neurological**

| | | |
|---|---|---|
| Numbness/tingling | Y | N |
| Weakness | Y | N |

**ALLERGIES**: Do you have any allergies to any medications? YES NO If yes, please list__________________

**SURGICAL HISTORY**: ____________________________________________________________________________

____________________________________________________________________________________________

**MEDICATIONS**: Please list all of your medications, including OTC and herbal, etc.: _________________________

____________________________________________________________________________________________

**SOCIAL HISTORY**:

Is there a chance you could be pregnant? YES NO

Do you smoke? YES NO
If yes, how much per day? _______ packs

Do you drink alcohol? YES NO
If yes, how much/how often? __________________

Do you use recreational drugs? YES NO
If yes, what type? ___________________________

Do you use any assisted devices?

Cane ____ Walker_____
Wheelchair_____

Occupation: ______________________________
Are you currently working? YES NO
If no, reason? ______________________________

Height: _______ ft _______inches
Weight: _______ lbs.
Shoe size: _________

**FAMILY HISTORY** (Please indicate any condition(s) that your FAMILY has:)

Diabetes Y N Blood clots Y N Blood disorder Y N Heart disease Y N

**CHIEF COMPLAINT**: What is the reason that prompted you to make this appt? ___________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

How long has this problem/symptom(s) been present? _____________
Have you tried or received any prior treatment for this condition? YES NO
Please explain prior treatment_____________________________________________________________________________

***I authorize Dr. Stephanie Carollo/Tender Foot & Ankle Care, PLLC to release any medical information necessary to process my insurance claim, and I authorize payment of medical benefits to be made to this practice for services rendered. I agree to pay all of my copays, co-insurances, deductibles, and any balance that is denied or in dispute by my insurance company.***

**SIGNATURE**: ______________________________________________________ **DATE**: ________________________
Patient, parent, or responsible party

# PATIENT HIPAA ACKNOWLEDGEMENT
# AND DESIGNATION DISCLOSURE FORM

**Acknowledgement of Practice's Notice of Privacy Practices**: by subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

1. **Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative**: I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. In the case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

   Print Name: ______________________________________________

   Print Name: ______________________________________________

2. **Request to Receive Confidential Communications by Alternative Means**: I hereby request that the office make verbal communications to me by the means I have listed below.

   **Cellular phone number:** ____________________________________________

   ☐ Okay to leave message with detailed information, OR
   ☐ Okay to leave message with call back numbers only

   **Home phone number:** ____________________________________________

   ☐ Okay to leave message with detailed information, OR
   ☐ Okay to leave message with call back numbers only

| ______________________________ | ____________________ | ______________________________ |
|---|---|---|
| Patient Name (Printed) | Today's Date | Signature of Patient/Parent/Guardian |