Dr. Japera Levine D.P.M.
350 Pine St. Suite 1420
Downtown Beaumont

Adult Patient Information Form
Please Print-Mark "N/A" If It Does Not Apply To You

Date:____________________

Full Name: ____Date Of Birth: ______________________
Last First Middle

Gender: ___ Male ___ Female Social Security#: ____-___-_____ Shoe Size: _______

Race: ___ American Indian/Native ___ Asian ___Black/African American ___Caucasian/White
___ Hispanic/Latino ___Hawaiian/Pacific Islander

Home Phone/Alternate Number:____________________________________ Cell Phone:____________________

Mailing Address:____
Street Address City Zip

Marital Status: ___Child ___Single ___Married ___Separated ___Divorced ___Widowed

Employer:____Title/Occupation:_____________________________

Pharmacy:________________________________ Location: ___________________ Phone #: _____________________________

Emergency Contact Name (Not Living In The Your Home): ____
Relation:______________________________ Phone:____

Primary Care Physician:____ Phone:_________________________

When Did You Last See Your PCP? ____________________

Pain Management Physician: ___________________________ Phone: __________________________________

When Did You Last See Your Pain Management? ____________________

Who Referred You? ___________________________

Responsible For Payment (Full Name):____________________ Date Of Birth: __________________SSN: ____________

Insurance 1st:____________________________________ Policy #: ____________________________________

Policy Holder & Relationship: __________________________________ Group#: _____________________________

Date Of Birth: ____ SSN: ____

Insurance 2nd:___________________________________ Policy #: ____________________________________

Policy Holder & Relationship: __________________________________ Group#: _____________________________

Date Of Birth: ____ SSN: ____

Reason For Visit Today? Be Specific

____

Is This Workers Comp? ___Yes ___No

To The Best Of My Knowledge, I Will Answer The Questions On These Forms Accurately. I Understand That Providing Incorrect Information Can Be Dangerous To My Health. I Understand That It Is My Responsibility To Inform The Doctor And Office Staff Of Any Changes In My Medical Status. Dr. Japera N. Levine Dpm Pllc Offers Her Patients The Opportunity To Communicate By E-Mail. This Form Provides Information About The Risks Of E-Mail, Guidelines For E-Mail Communication And How We Will Use E-Mail Communication. It Also Will Be Used To Document Your Consent For Us To Communicate With You By E-Mail By Instructing You On How To Setup Your Patient Portal.

Patient/Parent/Guardian Signature: ________________________________

Signature of person filling out document if different from the patient:

____

Family History- Please List Any Medical History That Your Family May Have That May Or May **Not** Be Foot Related:

Relation To Member:	RELATED History:	Living Or Deceased:
Father		
Mother		
Spouse		
Son/Daughter- Circle One		

Patient's Medical History- Please Circle "Y" For Yes/"N" For No

Acid Reflux	Y/N	Fibromyalgia	Y/N	Open Sores	Y/N
Anemia	Y/N	Gout	Y/N	Pneumonia/Vaccine	Y/N
Arthritis	Y/N	Heart Attack	Y/N	Polio	Y/N
Asthma	Y/N	Heart Disease	Y/N	Heart Failure	Y/N
Back Trouble	Y/N	Hepatitis	Y/N	Sickle Cell Disease	Y/N
Bladder Infections	Y/N	Hiv/Aids	Y/N	Skin Disorder	Y/N
Abnormal Bleeding	Y/N	High Blood Pressure	Y/N	Sleep Apnea	Y/N
Blood Clots	Y/N	Kidney Disease	Y/N	Stomach Ulcers	Y/N
Blood Transfusion	Y/N	Liver Disease	Y/N	Stroke	Y/N
Bronchitis	Y/N	Low Blood Pressure	Y/N	Thyroid Disease	Y/N
Cancer	Y/N	Migraines/Headaches	Y/N	Tuberculosis	Y/N
Diabetes	Y/N	Mitral Valve Prolapse	Y/N	Influenza Vaccine	Y/N
Weight Loss Surgery	Y/N	Keloids	Y/N	Neuropathy	Y/N
Other:		Other:		Other:	
**** Value & Date of your last **hemoglobin A1C**?					

Patient's Social History

Use Of Alcohol- Type: ________________ _____Social ___Occasional ___Light ___Heavy ___Never

Use Of Tobacco: _____ Never ____ Smoke ____ Quit – How Long Ago? ________ Would you like to quit smoking? ______

Have you tried to quit smoking previously? ______ How many times have you tried to quit smoking? ______

Use Of Recreational Drugs: ____ Never ____ Current Use Type: ________________ ____ Quit – How Long Ago? ______

How Much Are You On Your Feet At Work? ___10% ___25% ___50% ___75% ___100%

Do Others Depend Upon You For Their Care? ___Children–AGE (S): ______________________

____PET (S)–WHAT KIND? __________ ____ ELDERLY OR DISABLED FAMILY MEMBER
____ OTHER: ________________

EXERCISE: ____NEVER ____RARE ____OCCASIONAL ____WEEKLY ____SEVERAL TIMES A WEEK ____DAILY

TYPES OF EXERCISE:
____

PATIENT'S SURGICAL HISTORY

TYPE OF SURGERIES (PLEASE LIST RIGHT OR LEFT)	**YEAR**

REVIEW OF SYSTEMS- PLEASE CHECK ALL THAT APPLY

CONSTITUTIONAL:	**URINARY:**	**BREAST:**
CHILLS Y/N	AWAKENING TO URINATE Y/N	DISCHARGE Y/N
FEVER Y/N	BURNING Y/N	LUMPS Y/N
WEIGHT LOSS/GAIN-CIRCLE ONE Y/N	FLANK PAIN Y/N	TENDERNESS Y/N
WEAKNESS Y/N	INFECTIONS Y/N	PAIN Y/N
FATIGUE Y/N	STONES Y/N	
	URINE ODOR Y/N	**SKIN:**
HEAD:	BED-WETTING Y/N	DRYNESS Y/N
DIZZINESS Y/N	DIFFICULTY STARTING STREAM Y/N	ITCHING Y/N
FAINTING Y/N	FREQUENCY Y/N	NAIL APPEARANCE CHANGE Y/N
PAIN Y/N	URGENCY Y/N	SKIN COLOR CHANGE Y/N
HEAD INJURY Y/N	BLOOD IN URINE Y/N	EASILY BRUISED Y/N
SWEATS Y/N	EXCESSIVE URINATION Y/N	HAIR TEXTURE CHANGE Y/N
	INCONTINENCE Y/N	NAIL TEXTURE CHANGE Y/N
EYES:	RETENTION Y/N	ECZEMA Y/N
BLURRY/DOUBLE VISION Y/N	URINE DISCOLORATION Y/N	MOLE INCREASED SIZE Y/N
EYEGLASS USE Y/N		RASHES Y/N
PAIN W/ LIGHT Y/N	**CARDIOVASCULAR:**	
UNUSUAL SENSATION Y/N	CHEST PAIN Y/N	**NEUROLOGICAL:**
CATARACTS Y/N	HAIR LOSS ON LEGS Y/N	BLACKOUTS Y/N
EXCESSIVE TEARING Y/N	SWELLING OF LEGS Y/N	FAINTING Y/N
GLAUCOMA Y/N	VARICOSE VEINS Y/N	LOSS OF CONSCIOUSNESS Y/N

Recent Injury Y/N	Cold Extremities Y/N	Paralysis Y/N
Vision Loss Y/N	Heart Murmur Y/N	Tingling Y/N
Discharge Y/N	Thrombophlebitis Y/N	Burning Y/N
Eye Pain Y/N	Discolored Extremities Y/N	Speech Disorder Y/N
Infections Y/N	Heart Tests Y/N	Tremors Y/N
Redness Y/N	Rheumatic Fever Y/N	Numbness Y/N
	Ulcer On Legs Y/N	Unsteady Gait Y/N
Nose:		
Discharge Y/N	**Gastrointestinal:**	**Endocrine:**
Sinus Infections Y/N	Abdominal Pain Y/N	Cold Intolerance Y/N
Frequent Colds Y/N	Change In Stool Color Y/N	Goiter Y/N
Nasal Obstructions Y/N	Decreased Appetite Y/N	Neck Pain Y/N
Nosebleeds Y/N	Excessive Thirst Y/N	Weakness Y/N
	Hemorrhoids Y/N	Heat Intolerance Y/N
Ears:	Jaundice Y/N	Fatigue Y/N
Discharge Y/N	Nausea Y/N	Increased Thirst Y/N
Hearing Impairment Y/N	Swallowing Problem Y/N	
Ringing In Ears Y/N	Change In Frequency Of Bm Y/N	**Allergic/Immunologic:**
Infections Y/N	Diarrhea Y/N	Coughing Y/N
Hearing Aid Y/N	Gallbladder Disease Y/N	Itchy Eyes Y/N
Pain Y/N	Laxative Use Y/N	Runny Nose Y/N
	Rectal Bleeding Y/N	Watery Eyes Y/N
Throat/Neck:	Vomiting Y/N	Coughing W/ Exercise Y/N
Sore Throat Y/N	Antacid Use Y/N	Itchy Nose Y/N
Enlarged Tonsils Y/N	Constipation Y/N	Sneezing Y/N
Lumps Y/N	Excessive Hunger Y/N	Wheezing Y/N
Tenderness Y/N	Heartburn Y/N	Hives Y/N
	Infections Y/N	Recurrent Infections Y/N
Respiratory:	Rectal Pain Y/N	Stuffy Nose Y/N
Coughing Blood Y/N	Vomiting Blood Y/N	Wheezing W/ Exercise Y/N
Sputum Y/N		
Pain Y/N	**Musculoskeletal:**	**Psychiatric:**
Cough Y/N	Muscle Cramps Y/N	Behavioral Changes Y/N
Shortness Of Breath Y/N	Restricted Motion Y/N	Disturbing Thoughts Y/N
Palpitations Y/N	Joint Pain Y/N	Memory Loss Y/N
Exertion Y/N	Muscle Stiffness Y/N	Psychiatric Disorders Y/N
	Weakness Y/N	Depression Y/N

Hematological/Lymph:	Deformities Y/N	Excessive Stress Y/N
Swollen Glands Y/N	Joint Stiffness Y/N	Mood Changes Y/N
Bleeding Easily Y/N	Paralysis Y/N	Disorientation Y/N
Lumps Y/N		Hallucinations Y/N
Transfusion Reaction Y/N	**Females:** Are you Pregnant? Y/N	Nervousness Y/N
Blood Clots Y/N		
Radiation Exposure Y/N		

Please List All Medications You Are Currently Taking-Include Prescriptions, OTC Meds And Herbal Supplements

Name Of Med	DOSE (Mg/Ml/Mcg)	HOW Often Do You Take It?

Please List True Allergies Only & Your Reaction To Each Allergy:

Allergies (What Are You Allergic To):	Reaction (What Happens):

Consent For Photography, Videotaping, Or Other Imaging For Media/Educational Purposes

Patient's Name: _______________________________ Patient's Date Of Birth: ______________

Dr. Japera Levine Typically Takes Pictures Of Each Patient To Help Educate The Patient As Well As Other Patients' Who May Have A Similar Condition. Dr. Levine's Office Strictly Uses Pictures & Videos; We Will Keep Each Patient's Information Confidential. If You Agree Please Initial & Sign Below.
I Give My Consent To Have Photographs, Videotaped Images, Or Other Images Made Of **My Medical Condition & Myself.** I Understand And Agree That These Images May Be Used By Dr. Japera N. Levine DPM PLLC At **Any** Time For The Purpose (S) Outlined Below Without Compensation.

_____ Teaching Purposes (May Include Being Shown To Other Patients)

_____ Advertisements By Dr. Japera N. Levine DPM PLLC

_____ Placement On Dr. Japera N. Levine DPM PLLC'S Website

_____ Placement On Dr. Japera N Levine DPM PLLC'S Office Social Media

_____ Continuing Medical Education Or Board Certification Examinations

____ _____________
Signature Of Patient/Parent/Legal Guardian Date

E-Mail Consent/Agreement

Risks

Communication By E-Mail Has A Number Of Risks That Include, But Are Not Limited To, The Following:

- E-Mail Can Be Circulated, Forwarded, And Stored In Paper And Electronic Files.
- Backup Copies Of E-Mail May Exist Even After The Sender Or The Recipient Has Deleted His/hers Copy.
- E-Mail Can Be Received By Unintended Recipients.
- E-Mail Can Be Intercepted, Altered, Forwarded, Or Used Without Authorization Or Detection.
- E-Mail Senders Can Easily Type In The Wrong E-Mail Address.
- E-Mail Can Be Used To Introduce Viruses Into Computer Systems.

How We Will Use E-Mail

1) We Will E-Mail You Instructions To Set-Up Your Patient Portal.
2) We Will Limit E-Mail Correspondence To Established Patients Who Are Adults 18 Years Or Older, Or The Legal Representatives Of Established Patients.
3) We Will Use E-Mail To Communicate With You Only About Non-Sensitive And Non-Urgent Issues
4) All E-Mails To Or From You Will Be Made A Part Of Your Medical Record. You Will Have The Same Right Of Access To Such E-Mails As You Do To The Remainder Of Your Medical File.
5) Your E-Mail Messages May Be Forwarded To Another Office Staff Member As Necessary For Appropriate Handling.

6) We Will Not Disclose Your E-Mails To Researchers Or Others Unless Allowed By State Or Federal Law. Please
Refer To Our Notice Of Privacy Practices For Information As To Permitted Uses Of Your Health Information And Your Rights Regarding Privacy Matters.

I May Want To Communicate With Dr. Japera N. Levine DPM, PLLC, And The Office Staff By E-Mail. I Understand The Risks Of Communicating By E-Mail, In Particular The Privacy Risks Explained In This Form. I Understand That Dr. Japera N. Levine DPM PLLC Cannot Guarantee The Security And Confidentiality Of E-Mail Communication. Dr. Japera Levine Will Not Be Responsible For Messages That Are Not Received Or Delivered Due To Technical Failure, Or For Disclosure Of Confidential Information Unless Caused By Intentional Misconduct.

I Understand That I May Also Communicate With Dr. Japera Levine DPM, PLLC By Telephone Or During A Scheduled Appointment, And That E-Mail Is Not A Substitute For Care That May Be Provided During An Office Visit. Appointments Should Be Made To Discuss Any New Issues Or Any Sensitive Medical Information.

I Understand That Either Dr. Japera N. Levine DPM PLLC Or I May Stop Using E-Mail As A Means Of Communication Upon My Written Request. My Revocation Of Consent Will Not Affect My Ability To Obtain Future Health Care Nor Will It Cause The Loss Of Any Benefits To Which I Am Otherwise Entitled.

I Have Read And Understand This Form. I Have Had The Opportunity To Ask Questions And My Questions Have Been Answered To My Satisfaction. I Understand And Agree With The Information Contained In This Form And Give My Consent For E-Mail Communications To And From Dr. Japera N. Levine DPM PLLC.

E-Mail: ______________________ Signature: ______________________________________ Date: ______________________

Patient's Financial Responsibility Policy

- **Payment Is Due At The Time Of Service-Without Exception**. We Will Accept Visa, MasterCard, Discover, Or Cash. We Do Not Accept Amex Or Check.

- Your Insurance Policy Is A Contract Between You And Your Insurance Company.
  It is your responsibility to know/understand your insurance benefits.
  As A Courtesy, We Will File Your Insurance Claim For You If You Assign The Benefits To The Doctor. If Your Insurance Company Does Not Pay The Practice Within A Reasonable Period, We Will Look To You For Payment.
  - **Copayments**: By Law We Must Collect Your Carrier Designated Copay At The Time Of Service.
  - **Referrals**: If Plan Requires A Referral From Your PCP It Is Your Responsibility To Obtain It Prior To Your Appointment.
  - **Non-Plan Patients/Non Insured**: Payment Is Expected At Time Of Service.
  - **Medicare**: We Will Submit To Medicare For The Entire Medicare Allowed Amount. The Patient Will Be Responsible For The Deductible And The 20% Co-Insurance, Which Can Be Billed Directly To Secondary Insurance If You Have One.

- We Have Made Prior Arrangements With Certain Insurers And Other Health Plans To Accept An Assignment Of Benefits. We Will Bill Those Plans With Which We Have An Agreement And
  Will Only Require You To Pay The Co-Pay/Co-Insurance/Deductible At The Time Of Service Or
  Any Services That Are Deemed Not Medically Necessary Or Covered By Your Plan.

- All Health Plans Are Not The Same And Do Not Cover The Same Services. In The Event Your Health Plan Determines A Service To Be "Not Covered," Or You Do Not Have An Authorization, You Will Be Responsible For The Complete Charge. We Will Attempt To Verify Benefits For Some Specialized Services Or Referrals; However, You Remain Responsible
  For Charges To Any Service Rendered. Patients Are Encouraged To Contact Their Plans For Clarification Of Benefits Prior To Services Rendered.

- You Must Inform The Office Of All-Insurance Changes And Authorization/Referral Requirements Prior To Your Arrival. In The Event The Office Is Not Informed, You Will Be Responsible For
  Any Charges Denied.

- For Most Services Provided In The Hospital, We Will Bill Your Health Plan. Any Balance Due Is Your Responsibility.

- Past Due Accounts Are Subject To Collection Proceedings. All Costs Incurred Including, But Not Limited To, Collection Fees, Attorney Fees, And Court Fees Shall Be Your Responsibility
  In Addition To The Balance Due To This Office. Your Past Due Balance Will Be Collected At Your Next Office Visit Or Be Paid Within 30 Days Of The Statement Date;
  Whichever Comes First. There Is A Service Fee Of $35.00 For All Returned Checks.
  Your Insurance Company Does Not Cover This Fee.

- Treatments For Injuries/Accidents Related To "On-The-Job" Or Automobile Accidents Involving Attorneys Are Required To Be Paid In Cash. We Will Not File Your Insurance For These Visits.

- We Are Sorry To Inform You That **All Nail/Callus Trimming Is Not A Covered Service By Your Insurance Plan** And Results In A $50 Charge Up Front. Any Medicaid Patients Requiring Diabetic Foot Exams Will Have An Out Of Pocket Expense. In Addition, Medicaid Will Not Cover Any Wound Debridement.

______________________________ ______________________________ ______________________________

(Signature) (Printed Name) (Date)