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

Pediatric 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

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? _____

Who Referred You? _____

Parent/Guardian Full Name:_____ Date Of Birth: _____SSN: _____

Parent/Guardian E-Mail: _____

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:

_____

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.

Parent/Guardian Signature: _____

Relationship to the PATIENT: _____

Family History- Please list any medical history that your family **may or may not** have:

Relation to member:	**Related history:**	**living or deceased:**
Father		
Mother		
Brother		Age:
Sister		Age:

Patient's Medical History

PLEASE LIST ANY MEDICAL CONDITION (S) YOUR CHILD MAY HAVE:

Condition/When it started?	How long has your child had this problem?

Is your child's condition getting better/worse? Please explain:

_____

Does the problem involve both sides of the body?

_____

Is there leg or foot pain in rest and/or with certain activities?

_____

Any current or past treatment for leg or foot pain?

_____

If yes, were there any successful treatments for them?

_____

Any significant medical problems: including medications, trauma, or surgery involving the mother during the time of the pregnancy?

_____

Any significant issues during delivery?

_____

Did your child have any issues meeting any of developmental milestones at the appropriate time?

_____

Does your child have any issues with school, speech, and learning?

_____

From a parent's perspective have you ever been concerned at all with any part of your child's lower extremity/type of walk/look of feet prior to today's visit?

_____

Does your child have any issues with fatigue, endurance, speed, posture, or general strength?

_____

PATIENT'S SURGICAL HISTORY

TYPE OF SURGERIES (PLEASE LIST RIGHT OR LEFT)	YEAR

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:
(INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER 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 IS YOUR CHLD ALLERGIC TO):	REACTION (WHAT HAPPENS):

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:**	
Redness Y/N	Rheumatic Fever	Y/N	Blackouts	Y/N
Excessive Tearing Y/N	Heart Tests	Y/N	Fainting	Y/N
Infections Y/N	Discolored Extremities	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			Speech Disorder	Y/N
	Gastrointestinal:		Tremors	Y/N
Nose:	Vomiting Blood	Y/N	Numbness	Y/N
Nosebleeds Y/N	Rectal Pain	Y/N	Unsteady Gait	Y/N
Nasal Obstructions Y/N	Infections Y/N			
Discharge Y/N	Heartburn Y/N		**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
	Decreased Appetite	Y/N	Neck Pain	Y/N
Ears:	Excessive Thirst	Y/N	Weakness	Y/N
Pain Y/N	Hemorrhoids	Y/N	Heat Intolerance	Y/N
Hearing Aid Y/N	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
	Gallbladder Disease	Y/N	Itchy Eyes	Y/N
Throat/Neck:	Laxative Use	Y/N	Runny Nose	Y/N
Tenderness Y/N	Rectal Bleeding	Y/N	Watery Eyes Y/N	
Lumps Y/N	Vomiting	Y/N	Stuffy Nose	
Sore Throat Y/N	Antacid Use	Y/N	Itchy Nose	Y/N
Enlarged Tonsils Y/N	Constipation	Y/N	Sneezing	Y/N
	Excessive Hunger	Y/N	Wheezing	Y/N
Respiratory:			Hives	Y/N
Palpitations Y/N	**Musculoskeletal:**		Recurrent Infections	Y/N
Shortness Of Breath Y/N	Paralysis	Y/N		
Coughing Blood Y/N	Joint Stiffness	Y/N	**Psychiatric:**	
Sputum Y/N	Deformities Y/N		Nervousness Y/N	
Pain Y/N	Weakness Y/N		Hallucinations Y/N	
Cough Y/N	Muscle Cramps	Y/N	Behavioral Changes Y/N	
	Restricted Motion	Y/N	Disturbing Thoughts	

		Y/N
HEMATOLOGICAL/LYMPH:	JOINT PAIN Y/N	MEMORY LOSS Y/N
TRANSFUSION REACTION Y/N	MUSCLE STIFFNESS Y/N	PSYCHIATRIC DISORDERS Y/N
LUMPS Y/N		DEPRESSION Y/N
BLEEDING EASILY Y/N	**FEMALES:** ARE YOU PREGNANT? Y/N	EXCESSIVE STRESS Y/N
SWOLLEN GLANDS Y/N		MOOD CHANGES Y/N
	SICKLE CELL DISEASE Y/N	DISORIENTATION Y/N

Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of patient: _____ Date of Birth: _____

This form is to authorize any person who is **NOT** the parent/guardian to be present with the patient for an office visit in the event the parent is not able to bring the patient in for their appointment.
By signing this document, you are giving the person listed below authorization to make medical decisions for your child in your absence.
To revoke authorization, a letter must written and new consent must be signed. The person authorized must present to office with a picture ID.
You may list more than one person, but any person not listed on this consent will be sent home without the patient being seen for their appointment.
Dr. Japera Levine is not responsible for any decisions made by the authorized personnel without the parent/guardian's knowledge.
Phone calls will not be permitted during the patient's visit in order for the parent/guardian to be contacted.
If you do not wish to authorize anyone other than the parent/legal guardian to bring the patient in for an appointment, please indicate that at the bottom of the page.
You can simply write, "Do not consent" in the blank space.
If you do not authorize anyone besides the parent/guardian to bring the patient in for his or her appointment, the parent/guardian must be present to each visit.
Any child under the age of 18 will **NOT** be seen without a parent/guardian/authorized person present.

Parent/Legal Guardian Name & Phone Number: _____

Authorized Person Name & DOB: _____
Phone Number: _____
Relationship to Patient: _____

Authorized Person Name & DOB: _____
Phone Number: _____
Relationship to Patient: _____

Authorized Person Name & DOB: _____
Phone Number: _____
Relationship to Patient: _____

Parent/Guardian Signature: _____ Date: _____

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)