Christopher Stroud, MD

Extremity Form

Date:_____

Name:_____ **Age:**_____

Chief Complaint:_____

Height_____ **Weight**_____

List all allergies with reaction to medications:_____

List current medications with names, dosages and frequencies (we are happy to copy a list if you have one).
Please include all over the counter medications including vitamins/herbals.

Medication Name	Dose	Frequency

Have you had a flu shot? Yes No If yes, approximate date _____

If over 65, have you had a pneumonia vaccine: Yes No If yes, approximate date _____

Review of Systems:

Have you ever had or do you currently have any of the following:

YES	NO		YES	NO	
___	___	Double/ Blurry Vision	___	___	Stomach Ulcers
___	___	Frequent Headaches/ Migraines	___	___	Diarrhea
___	___	Frequent Colds/ Sore Throat	___	___	Colitis
___	___	Swollen Lymph nodes in Neck	___	___	Anxiety
___	___	Thyroid Disease	___	___	Depression
___	___	Neck Pain	___	___	Diabetes
___	___	Bronchitis/ Pneumonia	___	___	Arthritis
___	___	Asthma	___	___	Bladder infection
___	___	Chest Pain/ Heart Attack	___	___	Varicose Veins
___	___	Shortness of Breath	___	___	Cancer
___	___	High Blood Pressure	___	___	Psoriasis
___	___	Epilepsy/ Seizures	___	___	Fibromyalgia
___	___	Back Pain	___	___	Rashes
___	___	Leg/ Ankle Swelling	___	___	Blood Clots
___	___	High Cholesterol			

List all medical conditions / problems:_____

_____

_____

List all previous surgeries including dates:_____

_____

_____

Family History:

Do any of **your family members** have (or ever had) any the following. Please circle or list if needed:
(Paternal/Maternal Aunts/Uncles/Grandparents/Sister/Brothers/Parents)

Diabetes	No	Mom	Dad	Son	Daughter	Mat Grandma	Mat Grandpa	Pat Grandma	Pat Grandpa	Other:	
High blood pressure	No	Mom	Dad	Son	Daughter	Mat Grandma	Mat Grandpa	Pat Grandma	Pat Grandpa	Other:	
Stroke	No	Mom	Dad	Son	Daughter	Mat Grandma	Mat Grandpa	Pat Grandma	Pat Grandpa	Other:	
Blood clotting disorders	No	Mom	Dad	Son	Daughter	Mat Grandma	Mat Grandpa	Pat Grandma	Pat Grandpa	Other:	
Cancer	No	Mom	Dad	Son	Daughter	Mat Grandma	Mat Grandpa	Pat Grandma	Pat Grandpa	Other:	
Anesthesia Problems	No	Mom	Dad	Son	Daughter	Mat Grandma	Mat Grandpa	Pat Grandma	Pat Grandpa	Other:	

Do you currently smoke? Yes No If yes, how many packs per day? _____ For how many years? _____

If no, have you ever smoked? Yes No If yes, what year did you quit?_____

Do you use smokeless tobacco? Yes No If yes, how much per day? _____ For how many years?_____

Do you drink? Yes No How many drinks per day? _____

Do you use recreational drugs? Yes No If yes, what type and how frequently? _____

How would you rate your pain on a scale of 1-10 (10 is amputation of the limb): _____

Occupation:

Recreational / Sporting Activities / Exercise:

Have you ever had a problem with Anesthesia?

It is our policy to electronically send all prescriptions allowed by law. Please list your preferred pharmacy name and location:

_____

Office Financial Policy – 2018
C. Christopher Stroud M.D., P.C.

The following represents our office financial policy. **PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.** This includes all co-pays, deductibles and coinsurances.

Insurance Coverage

- Is a contract that exists between you or your employer (or spouses employer) and the insurance company. Our relationship is with YOU, the patient, and not the insurance company.
- We STRONGLY encourage you to be educated on what your insurance covers, need for referral and which "network" you are required to use, if any.
- All charges are the responsibility of the patient. We will bill your insurance company, but any services not covered will be your responsibility.
- We rely on YOU to inform us of ALL insurances available and expect all patients to notify the office immediately of any changes to their insurance status. If this information is not provided, or withheld at the time service is rendered, you will be responsible for these charges. It will then be your responsibility to collect from the insurance company.
- Regarding worker's compensation and/or automobile claims:
    - If your claim is being disputed, you are responsible for payment. This dispute is your responsibility, even if there is an attorney involved or a claim is in progress.
    - Your health insurance carrier will not be billed until the dispute is settled.
    - We will gladly provide you with necessary paperwork/documentation at your request. A fee may be required for this service.

Outstanding Balances

- Patient account balances must be paid within 30 days. A rebilling charge of $5.00 may be added each month to unpaid balances over 30 days. Unacknowledged invoices over 90 days old will be forwarded for further collection efforts. Charges associated with these actions will be the responsibility of the patient.
- If paying the balance in full is not possible, please speak with the billing department located in our Macomb office at 586-416-6260 to determine if payment arrangements can be made.
- If payment is not made when due, or you otherwise fail to comply with your patient obligations, we reserve the right to terminate our relationship with you, in accordance with applicable ethical standards.

Other Fees

- $40.00 charge for returned checks
- $25.00 fee for appointments missed without notification 24 hours prior to the appointment.
- $10.00 fee for form completion/x-ray copies. We must have a one-week notice for these requests.
- $1.00 per page fee for record requests/record copying.
- All fees are due at the time of information request.

I have read, understand and accept the office financial policy of C. Christopher Stroud M.D., P.C.

Patient's Name (print):_____

Patient's/Guardian Signature:_____

Date:_____

Patient Information Form

Patient Name: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone _____

Email address:_____

Birthdate: _____ Age: _____ Sex: _____

Race Please circle one: African American/American Indian/Asian/Caucasian/ Native Hawaiian/Pacific Islander/Other/Unknown/Declined

Ethnicity Please circle one: Arab Descent Hispanic/Latino Other Unknown Declined

Preferred Language: English Other: _____

Patient Employer: _____ Phone: _____

Patient Occupation: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

Responsible Party Information (If other than patient)

Name: _____Home Phone: _____

Address: _____Relationship: _____

DOB: _____

Reason for seeing Doctor: _____

Date of Injury or Onset: _____ How did it happen: _____

Is this injury due to an auto accident, accident at work or involve a third party liability company? Circle one: Yes No

If yes, have you filed a claim? Circle one: Yes No

Who were you referred by: _____

Family Doctor: _____ City: _____

Consent to Treat/Authorization to Release Insurance Information:

I request/authorize medical and/or surgical treatment as may be deemed necessary and appropriate by the physician and designee/assistants participating in my care. I authorize the release of medical information necessary to process my claims and also authorize payment of medical benefits to C. Christopher Stroud, for services furnished to me or my dependent, if a minor. I also understand I will be responsible for all copays and deductibles not covered by my insurance(s).

☐ I have read the Notice of Privacy Practices for C. Christopher Stroud, MD and acknowledge a copy is available at my request.

☐ Please release information to: _____ ☐ None

Patient/Patient Representative/Parent Signature: _____ Date: _____