

201 WEST BIG BEAVER ROAD, SUITE 1140
TROY, MI 48084

PHONE: (248) 220-3310
FAX: (248) 220-3311

Patient Intake Form

Date: _____

Last Name: _____

First Name: _____

M.I.: _____

Street Address: _____

Apt./Suite: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Cell/Mobile Phone: _____

Date of Birth: _____

Age: _____

SS#: _____

Email Address: _____

Employer: _____

Occupation: _____

Street Address: _____

Apt./Suite: _____

City: _____

State: _____

Zip: _____

Work Phone: _____

Emergency Contact Name: _____

Phone Number: _____

Street Address: _____

Relationship: _____

City: _____

State: _____

Zip: _____

Did a physician refer you to Dr. Trupiano? Yes No

Name: _____

Specialty: _____

Phone: _____

Street Address: _____

Apt./Suite: _____

City: _____

State: _____

Zip: _____

If you were not referred by a physician, how did you hear about Dr. Trupiano?

Friend/Family: _____

DrTrupiano.com

Google

Dr Michael Schenden

RealSelf

**VIDEOTAPE AND PHOTOGRAPHS
RELEASE AND AUTHORIZATION**

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I hereby release, discharge and agree to hold harmless John M. Trupiano M.D., P.C. and ASPS and their affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Date: _____ Printed Name: _____
Signature: _____

I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization in the interest of public education.

Date _____ Printed Name: _____
Signature: _____

Patient Insurance Awareness

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to check with your insurance company prior to any office or hospital procedures. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit. Please remember – *your insurance policy is between you and your insurance company and not between the insurance company and your doctor.* Also, please be advised that lab work performed in the office is a completely separate charge from the physician’s charges.

Dr. Trupiano has no control over your insurance plan regarding co-pays, deductibles, and coinsurance. It is your responsibility to be familiar with your insurance plan(s) prior to proceeding with your consult and/or procedure. *It is for this reason, co-pays, deductibles, and coinsurance will be collected prior to being seen by Dr. Trupiano and/or before any surgical procedure that is performed.*

Your signature below verifies that you have read and understand this statement and all your questions have been answered.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

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Patient Insurance Information

Primary Insurance:

Secondary Insurance:

Group #: _____

Group #: _____

Contract #: _____

Contract #: _____

Name of Subscriber:

Name of Subscriber:

Subscriber's Date of Birth: _____

Subscriber's Date of Birth: _____

Subscriber's Employer:

Subscriber's Employer:

Patient's Relationship to Subscriber:

Patient's Relationship to Subscriber:

I give my authorization to release medical records to assist in the processing of my insurance claims. I also authorize payment of my claims to be mailed directly to the facility providing my services. I understand that I am completely responsible for any charges incurred and the billing of my insurance does not guarantee payment of the claim(s). Patient balances are due 30 days after an insurance coverage payment has been made. John M. Trupiano M.D., P.C. reserves the right to assess a service charge of \$20 per month for any unpaid balance over 30 days after the insurance coverage has been paid. No service charges will be assessed to a patient account where the patient has made payment arrangements with the Office Manager at John M. Trupiano, M.D., P.C. and payments are being made as agreed. Returned check fee applied is \$30.00. If this account is assigned to a collection agency or a lawsuit, the prevailing party may be entitled to reasonable attorney fees, \$50.00 cost of collection fee, and/or collection agency fee. Ninety (90) days after the date of service, any unpaid amounts will be processed for collection services or a lawsuit and finance charges applied. I agree to the terms of service and I authorize any treatment deemed necessary by John M. Trupiano, M.D.

Patient or Legal Guardian Signature

Date

Note to patients under the age of 18: You must have the consent of a parent or legal guardian before you can be seen and treated in this office.

This is to confirm that I give my permission to have _____, a minor, examined and treated. It is requested that this includes a complete exam, and treatment.

Patient or Legal Guardian Signature

Date

Please present your insurance card(s) and driver's license with this form. Thank you.

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HIPAA Consent for Purposes of Treatment, Payment, and Healthcare Operations

With my consent, John M. Trupiano, M.D., P.C. may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to John M. Trupiano, M.D., P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

My Protected Health Information means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This Protected Health Information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. And, that John M. Trupiano, M.D., P.C. reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to John M. Trupiano, M.D., P.C., Attn: Privacy Officer, at 201 West Big Beaver road, Suite 1130, Troy, MI 48084.

With my consent, John M. Trupiano, M.D., P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and prescriptions among others.

With my consent, John M. Trupiano, M.D., P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, John M. Trupiano, M.D., P.C. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that John M. Trupiano, M.D., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to John M. Trupiano, M.D., P.C. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, John M. Trupiano, M.D., P.C. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Patient Name: _____

JOHN M. TRUPIANO, MD, FACS

Date: _____

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Medical History: Check the conditions which apply to you. Write the approximate year of occurrence or onset next to each checked condition.

✓	YEAR	CONDITION	✓	YEAR	CONDITION	✓	YEAR	CONDITION
		Anemia			Deep Vein Thrombosis (DVT)			High Blood Pressure
		Anesthetic Reaction			Diabetes (Insulin: Y/N)			High Cholesterol
		Angina/Chest Pain			Drug Dependency			Hypoglycemia
		Arthritis			Emphysema			Hypothyroidism
		Asthma			GERD/Acid Reflux			Irregular Heart Beat
		Bladder Infection			Glaucoma			Kidney Problems
		Bleeding Problem			Headaches/Migraines			Paralysis
		Blood Transfusion			Hearing Problems			Seizures/Convulsions
		Breathing Problem			Heart Attack			Skin Disorders
		Bronchitis			Heart Failure			Stroke
		Cancer (type:)			Heart Murmur			Ulcers
		Circulation Problem			Hepatitis/Jaundice			Tuberculosis
		Cirrhosis			Hiatal Hernia			Other:

Operations and Hospitalizations: List all prior operations that you have had and medical problems for which you have been hospitalized. Give approximate year of occurrence.

YEAR	OPERATION/ MEDICAL PROBLEM	YEAR	OPERATION/ MEDICAL PROBLEM

Medications: List all medications (prescription and non-prescription) you are presently taking. Include frequency and dose.

MEDICATION	FREQUENCY	DOSE	MEDICATION	FREQUENCY	DOSE

Allergies: List all known drug allergies and reaction.

ALLERGIC TO:	REACTION	ALLERGIC TO:	REACTION

Patient Name: _____

JOHN M. TRUPIANO, MD, FACS

Date: _____

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Social History:

Marital Status: Single Married Separated Divorced Widowed
Tobacco Use: Never Quit _____ years ago Current packs per day ____x____ years
Alcohol Use: Never Rarely Moderate Daily
Street Drug Use: Never Type/Frequency _____

SYSTEM REVIEW: Please check Yes or No for each item.

Height: _____

Weight: _____

General Symptoms

Good general health lately Yes No
 Fatigue Yes No

Eyes

Glaucoma Yes No
 Cataracts Yes No
 Visual changes Yes No

Ears/Nose/Mouth/Throat

Chronic sinus problems Yes No
 Sore throat Yes No
 Swollen glands in neck Yes No

Cardiovascular

High blood pressure Yes No
 Chest pain/angina Yes No
 Pacemaker Yes No

Respiratory

Chronic or frequent cough Yes No
 Shortness of breath Yes No
 Sleep apnea Yes No
 Asthma Yes No
 Emphysema Yes No
 Tuberculosis Yes No

Breasts

Pain in breasts Yes No
 Discharge from nipple(s) Yes No
 Breast mass/lump Yes No
 Previous breast surgery Yes No
 Regular mammograms Yes No
 Date of last mammogram: _____

Gastrointestinal

Poor appetite Yes No
 Nausea or vomiting Yes No
 Frequent diarrhea Yes No
 Constipation Yes No
 Blood in stool Yes No

Genitourinary

Frequent urination Yes No
 Blood in urine Yes No
 Incontinence/dribbling Yes No
 Kidney failure/dialysis Yes No
 Kidney transplant Yes No
 Discharge from penis/vagina Yes No

Integument (Skin)

Bleeding or bruising tendency Yes No
 Change in mole Yes No

Musculoskeletal

Joint pain Yes No
 Joint stiffness Yes No
 Weakness of muscles or joints Yes No
 Back pain Yes No
 Osteoarthritis Yes No

Neurological

Frequent/recurring headaches Yes No
 Light headed or dizzy Yes No
 Fainting or unconscious spells Yes No

Endocrine/Hepatic

Excessive thirst/urination Yes No
 Diabetes Yes No
 Heat/cold intolerance Yes No
 Thyroid disease Yes No
 Hepatitis Yes No

Hematologic/Lymphatic

Anemia Yes No
 Human Immunodeficiency Virus Yes No

Psychiatric

Depression Yes No
 Claustrophobia Yes No