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SPECIALISTS OF ILLINOIS

# Registration

Name _____ Date of Birth _____ Male / Female

Address _____ City _____ Zip _____

Preferred Phone Number: _____ Other Phone Numbers: _____

*Appointment confirmation calls will always be made to the preferred phone number and a message with your appointment details will be left, By Selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well as know all past appointment history*

May we leave detailed messages? Yes____ No_____ Occupation _____

Preferred Language _____ Email _____

How did you hear about us? _____

Emergency Contact/Relationship _____Phone _____

May we disclose to your Emergency Contact (**circle all that apply**), By Selecting appointment information this individual has the right to confirm, change, and cancel appointments, as well as know all past appointment history*

Billing Information Medical Information Appointment Information

Do you have a legal guardian or Healthcare Power of Attorney: Yes No

If yes, Name: _____ Relationship:_____ Phone:_____

**Are you a student**: YES NO **Marital Status**: Single Married Divorced Widow

**Please indicate your race**: African American American Indian/Alaska Native Asian Hispanic/Latino Native Hawaiian or Other Pacific Islander White Decline to answer

Primary Insurance _____ Secondary Insurance _____

Policy Holder _____ Policy Holder _____

Date of Birth _____ Date of Birth _____

Relationship _____ Relationship _____

**Financially Responsible Party Information** (if different than patient)

Name:_____Relationship:_____

(First) (MI) (Last)

DOB:_____ Phone Number:_____

Address:_____

**IF UNDER 18 YEARS OLD-**

Mom's Name: _____ Dad's Name:_____

Mom's Address:_____

Dad's Address:_____

Is this related to a worker's compensation claim? YES NO Motor vehicle accident? YES NO

***IF YOUR CURRENT PROBLEM IS DUE TO A WORK RELATED INJURY PLEASE NOTIFY RECEPTIONIST SO THAT YOU CAN FILL OUT WORK COMPENSATION FORMS, IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH THE NECESSARY INFORMATION REGARDING YOUR CLAIM.***

Insurance Company _____ Claim # _____ Date of injury _____

Adjuster _____ Phone _____

Family Physician _____ Last Visit Date _____

Address _____ Phone _____

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Allergies: I have no known allergies to medication:_____

**Check if you have allergies to the following and state your reaction:**

Other:_____/_____ Penicillin:_____/_____ Cortisone:_____/_____
Codeine:_____/_____ Sulfa:_____/_____ Iodine/Shell Fish:_____/_____
Latex:_____/_____ Lidocaine/Marcaine : _____/_____ Adhesive Tape:_____/_____

Preferred Pharmacy _____ Location _____

**Please list prescription and over the counter medications**

NAME: DOSE: HOW OFTEN DO YOU TAKE?

_____
_____
_____
_____

## Family History

| | Mother | Father | Siblings | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|
| Alive/Deceased | | | | | | | |
| Diabetes | | | | | | | |
| Heart Disease | | | | | | | |
| Stroke | | | | | | | |
| Cancer | | | | | | | |

## Medical History: Please mark if you have had any of the following

| | | | |
|---|---|---|---|
| ___ AIDS/HIV | ___ Bleeding/Clotting Disorders | ___ Gout | ___ Low Blood Pressure |
| ___ Anemia | ___ Cancer | ___ Heart Disease | ___ Numbness Where? _____ |
| ___ Arrhythmia | ___ Chemical Dependency | ___ Hemophilia | ___ Peripheral Vascular Disease (PVD) |
| ___ Arterial Plaque/Stenosis Where? _____ | ___ Chest Pain | ___ Hepatitis or Jaundice | ___ Psychiatric Care |
| ___ Arthritis | ___ Cysts or Masses Where? _____ | ___High Blood Pressure | ___ Radiation Treatment |
| ___ Artificial Heart Valves | ___ Deep Vein Thrombosis (DVT) | ___ High Cholesterol | ___ Shortness of Breath |
| ___ Asthma | ___ Diabetes | ___ Kidney Disease | ___ Skin Sensitivity / Disturbance |
| ___ Back Problems | ___ Foot/Leg Ulcers | ___ Liver Disease | ___Varicose Veins |

Tobacco use? _____Type of Tobacco use?_____ How much per day? _____ Quit how long ago? _____
Alcohol use? ___ Never ___ Rarely ___ Moderate ___ Daily
Type of Drinks Consumed:_____
Recreational drugs? YES_____ NO_____

**PLEASE LIST ALL PRIOR SURGERIES:**

Date/Year Type Surgeon Location

_____
_____
_____
_____
_____
_____

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**How much are you on your feet at work(circle one)** 10% 25% 50% 75% 100% **At Home?** 10% 25% 50% 75% 100%
Exercise**:** Never____ Rare_____ Occasionally_____ Weekly_____ Several Times/Wk _____ Daily_____
Type of Exercise**:**_____

Height _____ Weight _____ Shoe Size/Width _____

If Female, is there a chance you are pregnant? Yes_____ No_____
Do you have swelling in your limbs? _____ Arms _____ Legs Pain in your limbs? _____Arms _____ Legs
How often? _____ Region? _____ When? _____ At Rest _____ After Exercise

Have you experienced 2 falls OR any falls with injury in the last year? YES_____ NO_____
Do you have a living will or advanced directive? We will require a copy to keep on file. YES_____ NO_____

**WHAT SPECIFIC PROBLEM BRINGS YOU TO THE OFFICE TODAY? LIST LOCATION AND GIVE A BRIEF DESCRIPTION INCLUDING WHAT AGGRAVATES YOUR CONDITION AND WHAT MAKES YOUR CONDITION IMPROVE:**

PROBLEM#1:_____
LOCATION?_____ WHEN DID YOU FIRST EXPERIENCE THIS PROBLEM?_____
WHAT TREATMENT HAVE YOU HAD?_____
PROBLEM#2:_____
LOCATION?_____ WHEN DID YOU FIRST EXPERIENCE THIS PROBLEM?_____
WHAT TREATMENT HAVE YOU HAD?_____
PROBLEM#3:_____
LOCATION?_____ WHEN DID YOU FIRST EXPERIENCE THIS PROBLEM?_____
WHAT TREATMENT HAVE YOU HAD?_____

**If you are diabetic**, who is the doctor managing your diabetes? _____
Kidney doctor? Who? _____ Eye doctor? _____Last eye exam? _____
Are you taking insulin: No_____Yes_____ How many years have you been a diabetic:_____
Last HgA1c (Hemoglobin A1c):____Lowest blood sugar level in past month:_____ Highest sugar level in past month:_____
Have you ever had a foot/leg ulcer? No_____Yes_____ if yes, which foot and where:_____
How long did you have your ulcer:_____
Do you have an ulcer now: No___Yes___ If yes, describe where, the duration and treatments:
_____
_____
Have you had an amputation of part or all of your foot? No_____ Yes_____ If yes, describe:
_____
_____
_____
Have you ever been told you had poor circulation to your feet: No___ Yes___ If yes, describe:_____
Have you ever been told you had poor sensation to your feet: No_____ Yes____ If yes, describe:_____
Have you ever had Diabetic Shoes with Inserts: No__Yes___ If yes, where & when did you get your last pair?
_____

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# ***Office Policy***

Thank you for choosing our office to provide your medical care. We are committed to serving you with skill and high quality care. The medical services you have elected to have provided by our office imply some financial responsibility on your part.
**ASSIGNMENT OF BENEFITS:** I hereby assign or transfer benefits made to me and my behalf to Foot and Ankle Specialists of Illinois for any services furnished to me by this physician. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

**RELEASE OF INFORMATION:** I hereby authorize Foot and Ankle Specialists of Illinois to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

**Consent:** I certify that the above information is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment.
**INSURANCE:** We file claims as a courtesy to our patients. We file primary and secondary insurance only. Please check with your insurance that we are in network. **It is your responsibility to know your insurance benefits.**
**COPAYMENTS/DEDUCTIBLES:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We can only give an **estimated** cost of services based on information the insurance company provides us. **The amount applied to your deductible is determined by the insurance company and based on when the claim is processed, *not* when you were seen.**
**PRE-APPROVALS/REFERRALS:** You the patient or the insured is responsible for the initial call to your insurance company if pre-approval is required and to your primary care doctor if your insurance requires referrals. This is the policy of the insurance company. We will obtain any additional authorizations if needed for continued treatment.

**CANCELLATIONS:** We require 24 hour notice on all cancellations so we may have the opportunity to schedule another patient that may need an appointment. There is a $25 charge for any missed appointments or cancellations with less than 24 hour notice.

**PAYMENTS:** We accept the following payment methods: Cash, Check and Visa/MasterCard, American Express and Discover. Please let us know if you have any difficulties in resolving your bill.

**REFUNDS:** No refunds or exchanges will be given on any products sold out of our office. ALL sales are final.

**RETURN CHECK FEE:** An additional $30 will be added to your statement if the check is returned for any reason.

**ACKNOWLEDGEMENT FORM:** I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

**EMAIL & Text:** By providing my email address and Cell Phone number on the registration form, I "opt in" to a reasonable amount of correspondence from Foot and Ankle Specialists of Illinois to that address. I understand that I may "opt out" or revoke permission at any time and that my email address/cell phone number will not be given to any other party.

_____ _____

**Patient/ Parent/ Guardian Signature** **Date**

_____ _____

Office Staff Date

***If you should have any questions regarding our policies, please let us know. Thank you.***