WELCOME

PATIENT INFORMATION

Date _____
SS# / SIN _____
Patient Name _____
Wishes to be called _____
Mailing Address _____
_____
Physical Address _____
_____
Sex __ Female __Male Age ____
Birthdate _____
___Married ___ Widowed ___Single ___ Minor
___Separated ___ Divorced ___ Partnered for __ years
Patient Employer/School _____
Employer/School Address _____
_____
Employer/School Phone ( ) _____
Referred by _____

PHONE NUMBERS

Home Phone _____
Work Phone _____ Ext. # _____
Cell Phone _____
Where do you prefer to receive calls?
___ Home ___ Work ___ Cell
Best time to reach you? _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____
Phone Numbers _____

WHO IS RESPONSIBLE FOR THIS BILL

____ Same as Above
Name _____
Relationship to Patient __ Self __ Parent __Spouse __ Other
SS# / SIN _____ Birthdate _____
Mailing Address _____
_____
Physical Address _____
_____
___Employed; __ F/T__ P/T Employer _____
___ Not Employed ___ Retired
Occupation _____ Work Phone _____
Home Phone _____ Cell Phone _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and doctor's assistants or designed replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Date Signature of Beneficiary, Guardian Or Personal Representative

PRIMARY INSURANCE

Name of Insured _____
Relationship to Patient __ Self __ Parent __Spouse __ Other
Insured's birthdate _____
SS# / SIN _____
Mailing Address _____
_____
___Employed; __ F/T__ P/T Employer _____
_____ ___ Not Employed ___ Retired

Insurance Company _____
Group # _____ Employee/Cert. # _____
Ins. Co. Address _____

SECONDARY INSURANCE

____ No Secondary Insurance
Name of Insured _____
Relationship to Patient __ Self __ Parent __Spouse __ Other
Insured's birthdate _____
SS# / SIN _____
Mailing Address _____
_____
___Employed; __ F/T__ P/T Employer _____
_____ ___ Not Employed ___ Retired

Insurance Company _____
Group # _____ Employee/Cert. # _____
Ins. Co. Address _____
_____

ALL INSURANCE ASSIGNMENT AUTHORIZATION AND RELEASE OF INFORMATION

I certify that I have insurance coverage with _____ and assign directly to Dr. _____ all Insurance/Medicare/Medigap/Medicaid benefits, if any, otherwise payable to me for service rendered. **I understand that I am financially responsible for all charges whether or not paid by Insurance/Medicare/Medigap/Medicaid.** I authorize the use of my signature on all Insurance/Medicare/Medigap/Medicaid submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance/Medicare/Medigap/Medicaid benefits or the benefits payable for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date
Signature is required

_____
Please Print name of Beneficiary, Guardian or Personal Representative

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?
(include foot, ankle, knee, thigh and hip complaints) _____

_____

_____

Have you ever been to a Podiatrist before? ___ Yes ___ NO
If yes, please list.
Name _____ Last Visit _____
If yes, please list problems seen for: _____

_____

_____

Is there any personal or family history of diabetes? ____ Yes ____ NO
Your occupation _____
Cigarette/Tobacco use _____
Years Smoked _____
Athletic activities in which you participate

_____

_____

_____

MEDICAL HISTORY

AIDS/HIV	__Yes __ No	Epilepsy	__Yes __ No	Rash	__Yes __ No
Allergies to Anesthetics	__Yes __ No	Eye Problems	__Yes __ No	Respiratory Disease	__Yes __ No
Allergies to Medicine	__Yes __ No	Fainting	__Yes __ No	Rheumatic Fever	__Yes __ No
Allergies to Drugs	__Yes __ No	Foot or Leg Cramps	__Yes __ No	Shortness of Breath	__Yes __ No
Anemia	__Yes __ No	Gout	__Yes __ No	Sinus Problems	__Yes __ No
Angina	__Yes __ No	Headaches	__Yes __ No	Special Diet	__Yes __ No
Arthritis	__Yes __ No	Heart Disease	__Yes __ No	Stroke	__Yes __ No
Artificial heart valves	__Yes __ No	Hemophilia	__Yes __ No	Swelling in Ankles	__Yes __ No
Artificial joints	__Yes __ No	Hepatitis	__Yes __ No	Swelling in Feet	__Yes __ No
Asthma	__Yes __ No	Which Type __A __ B __C		Swollen Neck Glands	__Yes __ No
Back Problems	__Yes __ No	Jaundice	__Yes __ No	Tired Feet	__Yes __ No
Bleeding Disorders	__Yes __ No	High Blood Pressure	__Yes __ No	Tuberculosis	__Yes __ No
Cancer	__Yes __ No	Kidney Problems	__Yes __ No	Ulcers	__Yes __ No
Chemical Dependency	__Yes __ No	Liver Disease	__Yes __ No	Varicose Veins	__Yes __ No
Chest Pain	__Yes __ No	Low Blood Pressure	__Yes __ No	Venereal Disease	__Yes __ No
Chronic Diarrhea	__Yes __ No	Neuropathy	__Yes __ No	Weight Loss, (Unexplained)	__Yes __ No
Circulatory Problems	__Yes __ No	Phlebitis	__Yes __ No		
Diabetes	__Yes __ No	Psychiatric Care	__Yes __ No	High Cholesterol	__Yes __ No
Ear Problems	__Yes __ No	Radiation Treatment	__Yes __ No	Triglycerides	__Yes __ No

Surgeries you have had _____

_____

Hospitalization other that for the surgeries listed _____

_____

Family Physician _____ Last visit date _____
Are you now, or have you been, under any other doctor's care for any reason over the past two years? ____ Yes ____ No
If yes, please explain _____

MEDICATIONS

Include Prescriptions, over-the-counter medications and vitamins _____

_____

_____

_____

_____

_____

_____

Pharmacy Name(s) _____
Phone _____
Do you take oral Contraceptives? ____ Yes ____ No

ALLERGIES

___ Adhesive/Tape
___Anticoagulant Therapy
___Novacaine
___Penicillin
___Demerol
___Seafood
___Local Anesthetics
___Other _____
___ Sulfa
___Aspirin
___Codeine
___Iodine

SOUTHERN ILLINOIS FOOT AND ANKLE CLINIC
PATIENT RESPONSIBILITIES

1. A patient or his or her parent or legally designated representative has the responsibility to provide, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health. He or she has the responsibility to report unexpected changes in his or her condition to the responsible practitioner. A patient or his or her parent or legal designated representative is responsible for making it known whether he or she comprehends a contemplated course of action and what is expected of him.

2. A patient or his or her parent or legally designated representative is responsible for following the treatment plan recommended by the practitioner primarily responsible for the patient's care/services. This may include following the instruction of health care personnel as they carry out the coordinated plan of care/services and implement the responsible practitioner's orders and as they enforce the applicable clinic rules and regulations. The patient is responsible for keeping appointments and, when unable to do so for any reason, for notifying the responsible practitioner or the clinic.

3. The patient or his or her parent or legally designated representative is responsible for his or her actions if he or she refuses treatment or does not follow the practitioner's instructions. If the patient cannot follow through with the treatment, he or she is responsible for informing the physician.

4. The patient or his or her parent or legally designated representative is responsible for assuring that the financial obligations of his or her health care/services are fulfilled as promptly as possible. The patient is responsible for providing information for insurance. It is the responsibility of the patient or legal representative to pay in full for any supplies, co-insurance payments, or deductibles at the time of service. Any special payment arrangements must be made before the treatment/services or supplies are furnished. Ask the receptionist about financial arrangements.

5. The patient or his or her parent or legally designated representative is responsible for following clinic rules and regulations affecting patient care/services and conduct.

6. The patient or his or her parent or legally designated representative is responsible for being considerate of the rights of other patients and personnel, and for assisting in the control of noise, smoking and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the clinic.

7. A patient's health depends not just on his or her care/services but in the long term, on the decisions he or she makes in daily life. He or she is responsible for recognizing the effect of lifestyle on his or her personal life.

8. The patient, his or her parent or legally designated representative is responsible for contacting the clinic in advance to cancel/reschedule if the patient is unable to keep the appointment as scheduled. **Any appointment that is not cancelled 24 hours prior to the scheduled appointment time will be charged a $75.00 fee.** This charge will be billed to the patient directly, and he/she will be responsible for payment.

PAYMENT GUARANTEE

I do hereby expressly guarantee payment in full of any charges for goods and services which are not payable by my insurance and which are incurred by me or my family member. This includes but is not limited to any balances left unpaid by my insurance for any reason, deductibles and co-pays. I agree to pay all reasonable costs you incur to collect this debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. I understand that if any unpaid balance is turned over to our collection agency that a fee ranging from 33%-50% will be added to the total balance due. I hereby give you or any of your agents or assignees to whom you turnover any unpaid balance permission to obtain a report from a credit reporting agency and to take reasonable steps to verify my credit and or employment information. I give you or any of your agents or assignees to whom you turnover any unpaid balance permission to contact me at any telephone numbers of which they are aware including cellular telephones.

Signature _____ **Date** _____

PRIVACY INFORMATION

Due to the HIPPA laws (privacy act) Southern Illinois Foot and Ankle Clinic is required to ask your permission to share your information with others.

Please indicate below with whom we may share your health information.

This may include, but is not limited to: leaving a message regarding an appointment, appointments involving an upcoming surgery, instructions on what to do about a medical problem you may have inquired about, pharmacy or medication information, etc.

If I, the patient, am not available you may: *(check all that apply)*

☐ Leave a message on my answering machine or voice mail.

☐ Leave a message with my spouse. Name: _____

☐ Leave a message with my son or daughter. Name: _____

☐ Others that you may leave a message with: _____

☐ It is OK to call me at work.

☐ Talk to patient only.

*** Information will not be left with anyone except you, the patient, unless above authorization is obtained.**

NOTICE OF PRIVACY PRACTICES

I, _____, have read the above Notice of Privacy Practices and authorize the Southern Illinois Foot & Ankle Clinic to disclose the identified information to the persons and for the purpose described herein. I understand that by signing this document, I release Southern Illinois Foot & Ankle Clinic from any liability and will hold Southern Illinois Foot & Ankle Clinic harmless for any release made pursuant to this Authorization.

_____ _____

Signature of Patient or Legal Representative Date

_____

Description of Legal Representative's Authority