WELCOME

PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

City ______

State ______ Zip ______

E-mail ______

Sex ☐ M ☐ F Age ______ Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______ SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

PHONE NUMBERS

Home Phone (____) ______

Cell Phone (____) ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT

Name ______

Relationship ______

Home Phone (____) ______

Work Phone (____) ______

INSURANCE

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with ______
Name of Insurance Company(ies)

and assign directly to Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to ______
Name of

______ for any services furnished to me by that provider.
Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

______
Signature of Beneficiary, Guardian or Personal Representative

______
Please print name of Beneficiary, Guardian or Personal Representative

______ ______
Date Relationship to Beneficiary

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 ______

Is there any personal or family history of diabetes?
☐ Yes ☐ No

Your occupation ______

Cigarette/Tobacco use ______

Years smoked ______

Athletic activities in which you participate (please list and indicate frequency)

______

______

______

Please indicate which foot problems you now have or have had in the past.

Problem	Yes	No
Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

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MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Ear Problems	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Eye Problems	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis or Jaundice	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Neuropathy	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Rash	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swelling in Ankles, Feet	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

Surgeries you have had ______________________________

____

____

Hospitalization other than 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) ______________________________

Pharmacy Phone(s) (______) ______________________________

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

- ☐ Adhesive/Tape
- ☐ Anticoagulant Therapy
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Novocaine
- ☐ Penicillin
- ☐ Seafoods
- ☐ Sulfa

Other ______________________________

TREATMENT CONSENT

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

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative Date

______________________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

REVIEW OF SYSTEMS

SKIN
- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or nails

HEAD
- ☐ Headaches
- ☐ Head injury

EYES
- ☐ Glasses or contacts
- ☐ Change in vision
- ☐ Eye pain
- ☐ Double vision
- ☐ Flashing lights
- ☐ Glaucoma/Cataracts
- ☐ Last eye exam

EARS
- ☐ Change in
- ☐ hearing Ear pain
- ☐ Ear discharge
- ☐ Ringing
- ☐ Dizziness

NOSE/SINUSES
- ☐ Nose bleeds
- ☐ Nasal stuffiness
- ☐ Frequent colds

ALLERGIES
- ☐ Hives
- ☐ Swelling of lips or tongue
- ☐ Hay fever
- ☐ Asthma
- ☐ Eczema/Sensitive
- ☐ Sensitivity to drugs, food, pollens, or dander

MOUTH/THROAT
- ☐ Bleeding gums
- ☐ Sore tongue
- ☐ Sore throat
- ☐ Hoarseness

NECK
- ☐ Lumps
- ☐ Swollen glands
- ☐ Goiter
- ☐ Stiffness

BREAST
- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge
- ☐ BSE

RESPIRATORY/CARDIAC
- ☐ Shortness of breath ☐ Cough
- ☐ Production of phlegm, color
- ☐ Wheezing
- ☐ Coughing up
- ☐ blood Chest pain
- ☐ Fever
- ☐ Night sweats
- ☐ Swelling in hands/feet
- ☐ Blue fingers/toes
- ☐ High blood pressure
- ☐ Skipping heart beats
- ☐ Heart murmur
- ☐ HX of heart Medication
- ☐ Bronchitis/emphysema
- ☐ Rheumatic heart disease

GASROINTESTINAL
- ☐ Change of appetite or Weight
- ☐ Problems swallowing
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Abdominal pain
- ☐ Excessive belching
- ☐ Excessive flatus
- Yellow color of skin (jaundice/hepatitis)
- ☐ Food intolerance
- ☐ Rectal bleeding/ Hemorrhoids

URINARY
- ☐ Difficulty in urination
- ☐ Pain or burning on urination
- ☐ Frequent urination at night
- ☐ Urgent need to
- ☐ urinate Incontinence
- ☐ of urine Dribbling
- ☐ Decreased urine stream
- ☐ Blood in urine
- ☐ UTI/stones/prostate infection

PERIPHERAL VASCULAR
- ☐ Leg cramps
- ☐ Varicose veins
- ☐ Clots in veins

MUSCULOSKELETAL
- ☐ Pain
- ☐ Swelling
- ☐ Stiffness
- ☐ Decreased joint motion
- ☐ Broken bone
- ☐ Serious sprains
- ☐ Arthritis
- ☐ Gout

NEUROLOGIC
- ☐ Headaches
- ☐ Seizures
- Loss of Consciousness/Fainting
- ☐ Paralysis
- ☐ Weakness
- ☐ Loss of muscle size
- ☐ Muscle spasm
- ☐ Tremor
- ☐ Involuntary movement
- ☐ Incoordination
- ☐ Numbness
- Feeling of "pins and needles/tingles"

HEMATOLOGIC
- ☐ Anemia
- ☐ Easy bruising/bleeding
- ☐ Past Transfusions

ENDOCRINE
- ☐ Abnormal growth
- ☐ Increased appetite
- ☐ Increased thirst
- ☐ Increased urine production
- ☐ Thyroid trouble
- ☐ Heat/cold intolerance
- ☐ Excessive sweating
- ☐ Diabetes

PSYCHIATRIC
- ☐ Tension/Anxiety
- ☐ Depression/suicide ideation
- ☐ Memory problems
- ☐ Unusual problems
- ☐ Sleep problems
- Past treatment with Psychiatrist
- Change in mood/change in attitude towards family/friends

SIGNATURE____________

DATE_______________

Dundee Foot And Ankle
31 W. Dundee rd Wheeling, IL 60090 Office (847)-215-1525 Fax: (847)-215-7682

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that **Dundee Foot and Ankle** has the right to change its *Notice of Privacy Practices* from time to time. I understand that I may Request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that Dundee foot and ankle is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. I also understand that I may contact their Compliance Officer at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

Patient' Name: ______________________________

Relationship to Patients ______________________________ Date of birth __________

Signature: ______________________________

Do we have your permission to? ______________________________ Date: __________

Leave a message on your home answering machine regarding your appointment(s)? ☐ Yes ☐ No

Leave a message on your home answering machine asking you to call our office? ☐ Yes ☐ No

Contact you at your place of employment? Yes No

May we leave a message to remind you of appointments ☐ Yes ☐ No

Discuss and or coordinate your treatment plan with other care providers including, but not limited to, Physical Therapists, Trainers, etc. ☐ Yes ☐ No

Give the names of people with whom we can discuss your medical condition, including appointment information

Name ______________________________ Relationship __________

______________________________ Relationship __________

____

Patient Signature *(Guardian, if minor)* ______________________________ **Date (mm/dd/yyyy)**

Office Use Only

attempted to obtain the patient's signature in acknowledgement on this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below.

Date __________ **Initials** __________ **Reason** ______________________________

04

Paul Potach D.P.M.
31 West Dundee
Wheeling, Illinois 60090
847-215-1525

Cancellation, Rescheduling, None Payment Policy

Office Visit:

When you need to cancel or reschedule an office appointment, you must call our office at least **24 hours** prior to the scheduled time.

There will be a **$50.00** charge for not showing up or for not providing us with 24 hours noticed for canceling or rescheduling your appointment.

Surgery/Procedure

There is a lot of effort involved in scheduling a surgery. We must arrange for the doctor's, anesthesiologist and facility site for your care during the procedure.

Once a surgery is scheduled and confirmed there will be a $100 charge for canceling due to a non-documented medical reason or for not showing up.

These charges will be your responsibility and not your insurance company's.

You are responsible for your insurance co-pay,co- insurance and deductible in accordance with your insurance benefits plan. Please contact your insurance company to confirm your financial responsibility and obligation.

Non-payment patient's bills

I acknowledge that if I do not pay my balance according to the terms of my statement then my account will be turned over to a collection agency. I agreed to pay a 40% collection fee or any additional fees or charges imposed by the collection agency or those associated with the collection process.

I acknowledge receipt of this statement and I understand and agreed to the above terms.

____
Patient Signature

____
Date