ILLINOIS Foot & Ankle CENTER
Kelly N. May, DPM, AACFAS

PATIENT REGISTRATION

Patient Name: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

Preferred Phone: _____ ☐ Home ☐ Cell ☐ Work

Alternate Phone: _____ ☐ Home ☐ Cell ☐ Work

Email Address: _____ (Optional: for Patient Fusion access)

Employer: _____ Occupation: _____

Primary Doctor: _____

Emergency Contact Person: _____ Relationship: _____
Phone Number: _____

INSURANCE **** If patient is policyholder, skip section. If same address as patient, just write 'same'****

Primary insurance: _____
Name of policyholder: _____
DOB: _____
Address: _____
City: _____ State: ___ Zip code: _____
Phone Number: _____
Relation to Patient: ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance: _____
Name of policyholder: _____
DOB: _____
Address: _____
City: _____ State: ____ Zip code: _____
Phone Number: _____
Relation to Patient: ☐ Spouse ☐ Parent ☐ Other

GUARANTOR ****Person ultimately responsible for bills****

☐ Patient
☐ Policyholder of insurance (above)
☐ Other: Name: _____ Address: _____
Phone Number: _____ City: _____ State: ____ Zip code: _____

DEMOGRAPHICS

Preferred Language: ☐ English ☐ Spanish ☐ Polish ☐ Other: _____

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Other: _____

PATIENT HISTORY

MEDICAL HISTORY

□ **NONE**	□ Diabetes	□ High cholesterol
□ Anxiety	□ Fibromyalgia	□ Kidney problems
□ Arthritis	□ Gout	□ Liver Disease
□ Asthma	□ Heart disease	□ Neuropathy
□ Cancer: _____	□ Hepatitis	□ Stroke
□ COPD	□ High blood pressure	□ Other _____
□ Depression	□ HIV	□ Other _____

SOCIAL HISTORY

Do you smoke tobacco? ____Yes ____No If No: Did you ever smoke? ____Yes ____No
Do you drink alcohol? ____Yes ____No
Recreational drug use? ____Yes ____No

SURGICAL HISTORY

Procedure	Year

FAMILY HISTORY

	Father	Mother	Brother	Sister
Diabetes				
Heart Disease				
High Blood Pressure				
Arthritis				
Gout				
Thyroid				
Cancer (what type)				
Other				

ALLERGIES

□ **NONE** □ Penicillin □ Sulfa □ Iodine □ Aspirin □ Anesthetics □ Latex
□ Codeine □ Vicodin □ Cortisone □ Seasonal □ Food: _____
□ Other _____

MEDICATIONS *If you have a list, we will make a copy

Medication	Dosage	How Often?	For What?

Patient Name: _____

REASON FOR VISIT

Main Problem: _____ **Circle which foot:** Right Left

How Long: _____ Days _____ Weeks _____ Months _____ Years

Check all that apply:

Pain type: __ Burning __ Tingling __ Sharp __Dull __ Throbbing
__ Shooting __ Stabbing __ Numbness

Painful When: __ Standing __Walking __Lying in bed __ Worse in AM

Pain Level (Circle #) **1 2 3 4 5 6 7 8 9 10 (worst pain)**

Height: _____ Weight: _____ Shoe Size: _____

REVIEW OF SYSTEMS: Circle all that you are **currently** experiencing

General:	Fever	Chills	Weight Loss or Weight Gain
Eyes:	Vision changes	Eye injury	Eye irritation
Ear/Nose/Throat:	Hearing loss	Earache	Sore throat
Cardiovascular:	Chest Pain	Edema	Irregular beat
Respiratory:	Cough	Wheezing	Difficulty sleeping
Gastrointestinal:	Nausea	Vomiting	Diarrhea
Genitourinary:	Pain with urination	Frequent urination	
Musculoskeletal:	Muscle cramps/aches	Joint pain/swelling	Back pain
Circulation:	Leg cramps	Blood clots	Vascular disease
Neurological:	Headaches	Seizures	Numbness/tingling
Psychological:	Depression	Anxiety	Other: _____
Hematological:	Abnormal bleeding	Abnormal bruising	
Skin:	Rash	Itching	Suspicious lesions

HOW DID YOU HEAR ABOUT US?

□ Family/Friend: _____ □ Google □ Internet □ Insurance Company
□ Phone book □ Doctor Referral

ILLINOIS FOOT AND ANKLE CENTER, SC
TREATMENT AGREEMENT

I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

_____ _____
Patient Name (please print) Date

_____
Patient/Guardian Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
HIPAA

I hereby authorize this practice to disclose both orally and in writing all facts pertaining the the past, present, and future considerations, treatments, and services rendered with no exceptions. This includes diagnosis, prognosis, care and treatment, reports, testing, and changes. I understand that I may change this authorization in writing at any time. **Grab a free copy on the front desk.**

Please include any legal guardians. You may release to the following people:

Name	Relationship	Telephone

I acknowledge the Notice of Privacy Practices and I have read (or had the opportunity to read) and understand the Notice. You are welcome to keep the Notice.

_____ _____
Patient Name (please print) Date

_____
Patient/Guardian Signature

INSURANCE TERMINOLOGY

- This is for your knowledge and understanding. If you need further explanation, please contact your insurance company.

PREMIUM: the amount you pay every month towards your health insurance (NOT part of your deductible)

DEDUCTIBLE: the amount you must pay for your health care BEFORE your insurance benefits take effect

CO-PAY: the set amount you must pay for a health care service set by your insurance plan (usually paid per visit). A podiatrist is a specialist.

CO-INSURANCE: the percentage of health care cost you must pay once your insurer covers its share, it typically goes into effect once the deductible has been reached. For example, insurance will pay 80%, but you are responsible for the other 20%

OUT OF POCKET: the maximum you must pay and then insurance will pay 100%. This includes your total deductible as well as your 20% co-insurance payments.

ILLINOIS FOOT AND ANKLE CENTER, SC
FINANCIAL POLICY

PAYMENT FOR SERVICES: Payment for services are due once services are provided to you. We expect all charges we present to you at a visit will be paid at that visit, including copays and unpaid balances. You are responsible for copay amounts, coinsurance amounts, program deductibles, unpaid charges to account, and charges for services that are not covered by insurance or government programs, as determined by your insurance plan. Payments may be made by *cash, check, or credit card*. Payment plans can be agreed upon with a credit card on file. This must be discussed with the office. There will be a $25.00 charge for *returned checks*.

INSURANCE: If your doctor is a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have accurate insurance information and a copy of your identification card or claim form. Your insurance policy is a contract between you and your insurance company; therefore you are responsible for payment whether or not your insurance company pays. **Copays are due at the time of the visit.**

NO INSURANCE: If you do not have insurance or the doctor is not a participating provider with your insurance plan, all charges for the services will be paid at the time of the visit.

BILLING COMMUNICATIONS: We will present charges to you by written statements via the mail.

ASSIGNEMENT OF BENEFITS: I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductible, unpaid balances, and non-covered services. I authorize the release of information required to process my claims.

COLLECTIONS: A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have to be sent to a collection agency.

DISABILITY AND FMLA PAPERWORK: There is a $20.00 fee regarding any disability and FMLA paperwork that needs to be completed.

X-RAY COPIES: There is a $5.00 charge for copies of x-rays.

I have read and agree to the terms set forth in the above financial policy. I am financially responsible for any balance due. I agree to make all payments for any co-payments, charges due within my current deductible and any unpaid balance from previous visits at the time of my appointment. I agree to the Assignment of Benefits.

_____ _____

Patient Name (please print) Date

_____

Patient/Guardian Signature