

WELCOME
SOUTHERN ILLINOIS PODIATRY

PATIENT INFORMATION

Patient Name _____ Date of Birth ___/___/___ SS Number _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Email _____

Patient Employer _____ Employer Phone _____

You were referred by _____

I give my permission to leave messages on my telephone answering machine/voice mail about my appointments and/or medical care. You may speak with _____ about my medical claims and or medical care.

Marital Status _____

PRIMARY INSURANCE INFORMATION

Insurance Name _____ Phone _____

ID# _____ Group # _____

Insured Name If Different From Patient's Name _____ Insured Date of Birth _____

Insured Address If Different From Patient _____

Insured Phone _____ Insured Relationship to Patient ___ Spouse ___ Child ___ Other

Insured Employer Name _____ Phone _____

SECONDARY INSURANCE INFORMATION

Insurance Name _____ Phone _____

ID# _____ Group # _____

Insured Name If Different From Patient's Name _____ Insured Date of Birth _____

Insured Address If Different From Patient _____

Insured Phone _____ Insured Relationship to Patient ___ Spouse ___ Child ___ Other

GUARANTOR INFORMATION. If Different From Self (If this patient is under 18 or has a legal guardian)

Guarantor Name _____ Guarantor Phone _____

Guarantor Address _____

NOTICE OF PRIVACY PRACTICES (HIPPA REGULATIONS)

You were provided with a document entitled "Notice of Privacy Practices." It is required by governmental regulations that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you choose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, simply return it to the receptionist with your other materials.

CONSENT

I certify that the information included is true and correct to the best of my knowledge. I give permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet.

I authorize Southern Illinois Podiatry to bill my insurance company and receive the payments from them. I also authorize them to obtain a copy of my records from other providers and to share any information the insurance companies might need to process my claims. I also give my permission to the providers and their staff to treat me. I accept financial responsibility for any amounts my insurance company does not cover or pay.

Signature _____ Date ___/___/___

PATIENT HISTORY

***Please fill out all forms to the best of your ability. The staff will go over the form and answer any questions you have.**

Patient Name _____ Date ____/____/____

Age _____ Height _____ Weight _____ Shoe Size _____

PRIMARY CARE PHYSICIAN

Date Last Seen ____/____/____

(First & Last Name) _____ Phone _____

1) What is the main problem with your feet or ankles? _____

2) When did you notice the condition? _____

3) Is this an injury? ____ Yes ____ No If Yes, when did it occur? ____/____/____

If Yes, did it happen at work? ____ Yes ____ No

Are you claiming Workman's Comp? ____ Yes ____ No

If Yes, what is the Claim number and employer/contact person? _____

4) Check all of the following that apply?

Type of Pain Burning Tingling Sharp Dull Ache Throbbing

Shooting Stabbing Numbness

When Painful Upon Standing During Walking After Walking

During Sports Worse with Activity Better as Activity Continues

Worse when standing With Shoes Without Shoes

A.M. P.M. Lying in Bed Always

5) How painful is your condition? If 0= "no pain" and 10="the worst pain you have ever experienced", please circle your pain level: 0 1 2 3 4 5 6 7 8 9 10

6) How has this affected your daily routine and what activities does this keep you from performing?

7) Have you had foot care before? ____ Yes ____ No By whom and when: _____

8) Have you ever had an injury to the lower extremity? ____ Yes ____ No Explain _____

9) Are you pregnant? ____ Yes ____ No How many months? _____

REVIEW OF SYSTEMS

*If you experience any of the following please circle

Head: chronic headaches, concussions, dizziness, loss of consciousness. **Eyes:** glasses, contacts, double vision, blurred vision, blindness, cataracts. **Ears:** decreased or loss of hearing, ringing in the ears, chronic earaches. **Nose:** drainage or infection, bleeding, sinusitis. **Throat:** chronic tonsillitis, laryngitis, difficulty swallowing, loss of speech. **Cardiovascular:** chest pain, shortness of breath, palpitations, murmurs, heart valve disease, anemia, leg cramps. **Respiratory:** bronchitis, pneumonia, difficulty breathing, wheezing, chronic cough. **Gastrointestinal:** nausea, vomiting, diarrhea, constipation, weight gain or loss, blood in stool, black stool, loss of appetite. **Genitourinary:** chronic kidney or bladder infections, problems voiding, pain with urination, dark or bloody urine. **Other:** _____

Do your legs swell? ____ Yes ____ No

Do you have back problems or have had a back injury? ____ Yes ____ No

I am not experiencing any of the above symptoms.

1) SOCIAL HISTORY

Date of last physical exam ____/____/____ Occupation _____

Activities _____

Level of activity: ____ None ____ Occasional ____ Weekly ____ Competitive ____ Professional

Do you smoke tobacco?

Yes: # packs per day? ____ # cigarettes per day? ____ # of years smoking? ____

No: Did you ever smoke? ____ Yes ____ No If Yes: How long ago did you stop smoking? ____

Do you drink alcohol? ____ Yes ____ No

If Yes: How much? ____ <1 per week ____ 1-2 per week ____ 1-2 per day ____ more than 3 per day

Recreational drug use

Any type of drug use is a personal choice and will in no way adversely effect your relationship with the doctor. However, many drugs can interact with other medications and treatments with potential life threatening effects. Therefore, it is extremely important that you answer honestly. Your response will be held in the most strict patient-doctor confidentiality.

Answer ____ Yes ____ No If Yes: What substance and how often used _____

Race: American Indian Alaskan Native Asian Black Caucasian Pacific Islander
 Other Declined

Language: English Spanish Other _____

Ethnicity: Hispanic Non Hispanic Declined

2) MEDICAL HISTORY - Please check any of the following conditions that you have or have had in the past.

- Fibromyalgia Tumors Epilepsy Nerve Conditions Heart Problems
- Arthritis Asthma/COPD Gout Glaucoma Stomach Ulcers
- Skin Disorders Tuberculosis Anemia Bursitis AID(HIV)
- Lung Disease Kidney Problems Sickle Cell Stroke Hepatitis
- Osteoporosis Bleeding Problems Colitis/Crohn's Mental Disorders Poor Circulation
- High Blood Pressure Joint Implants Thyroid Disease Rheumatic Fever Heart Burn/Reflux
- Sexually Transmitted Diseases High Cholesterol
- Cancer; Type _____ Other _____

Diabetes: What is the name, phone number, and address of the doctor treating you for diabetes? _____

When was your last visit? ____/____/____

What is your average blood sugar reading? _____

Type I Type II

3) SURGICAL HISTORY

Procedure	Date	Complications

Have you ever been hospitalized other than for surgery? ____ Yes ____ No Explain _____

4) **FAMILY HISTORY** - Please check all that apply

	MOTHER	FATHER	BROTHER	SISTER
Arthritis				
Gout				
Cancer (what type)				
Heart Disease				
Diabetes				
High Blood Pressure				
Thyroid				
Other				

Pharmacy Name _____

Phone _____

Medication	Dosage	How Often Taken?	What Is It Taken for?

ALLERGIES

- | | | | |
|---------------------------------------|--|-------------------------------------|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Latex | <input type="checkbox"/> Metal | <input type="checkbox"/> Nickel |
| <input type="checkbox"/> Novacaine | <input type="checkbox"/> Anticoagulant Therapy | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Adhesive/Tape |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Demerol | <input type="checkbox"/> Darvacet | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Enviromental | <input type="checkbox"/> Food | | |

Other _____

Type of Reactions _____

Date of last flu vaccination? _____

Date of last pneumonia vaccination? _____

SOUTHERN ILLINOIS PODIATRY PATIENT FINANCIAL AGREEMENT

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full and is subject to our collections department.

Required Payments: Patients are encouraged and are responsible for knowing their benefits and applicable deductibles. Any Co-payments, co-insurance or remaining balances from previous charge must be paid at the time of services. All over-the-counter supplies must be paid at the time of service and are non-refundable.

Returned Checks: Our office charges \$40.00 plus any bank fees incurred on any checks returned by the bank.

No Show Fee/Late Cancellation Fee: There is a \$65.00 fee for missed appointments as well as cancellations with less than 24 hour notice. This fee must be paid to schedule another appointment.

Past Due Balance: If your account becomes past due we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay any fees that are incurred. Should the need to refer your account to an attorney, you agree to pay any attorney fees incurred plus court costs. In the event of this occurring, no future treatment at this office will be provided until paid in full.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court or should your past due account balance be reported to a credit reporting agency that your treatment at this office may become a matter of public record.

Divorce: In the instance of a divorce/separation, the party responsible for the account prior to the divorce remains responsible for the account. After the divorce, the parent authorizing treatment will be responsible for the charges incurred. Your divorce agreement is between you and your partner, not with SI Podiatry.

Transferring of Records: You will need to request in writing and pay a reasonable copying fee if you want to have copies of your records sent to another provider or organization. The amount of the fee varies depending on the number of pages we need to transfer. Your signature authorizes us to include all relevant information including your payment history. The same applies should you request your records transferred from another provider.

Effective date: Once this agreement is signed, you agree to all of the terms and conditions herein and the agreement will be in full effect.

My signature below indicates that I have read the above financial Policy and agree to its terms and conditions.

Print Patient Name: _____

Patient/Guardian Signature: _____

Relationship of Responsible Party: _____

Date: _____