CENTRAL DUPAGE FOOT & ANKLE SPECIALISTS

New Patient Information

Date: _____

Name: _____

Address: _____

City/State/Zip: _____

What is your preferred
Contact Phone Number? _____

Email Address: _____

Gender: M_____ F_____
Weight: _____ Height: _____ Shoe Size: _____

Race: _____
Preferred Language: _____

Single: _____ Married: _____ Divorced: _____
Widowed: _____

Patient Birth Date: _____ Age: ____

Patient SS#: _____

Patient's Occupation: _____
Employer Name: _____
Employer Phone: _____

Spouse or **Parent** Name: _____
Spouse or **Parent** Birth Date: _____
Spouse or **Parent** SS#: _____

Whom may we thank for referring you? _____
_____

Why are you seeking treatment? _____
_____
_____

Who is your Primary Care Physician?
First and Last Name **(MANDATORY)**

Dr.: _____
Address: _____
City/State/Zip: _____
Phone No.: _____

Have you seen a Podiatrist before? Y____ N____
If yes, whom? _____

Please check if you have had any of the following:

___ AIDS/HIV
___ anemia
___ bleeding disorder
___ blood clots/DVTs
___ cancer
Type: _____
___ chemo/radiation
___ circulation problems
___ diabetes
Type: _____
___ elevated cholesterol
___ foot/leg cramps
___ gout
___ heart attack
___ heart disease
___ hepatitis
Type: _____
___ high blood pressure
___ kidney disease
___ liver disease
___ phlebitis
___ prostate disease
___ respiratory disease
___ rheumatic fever
___ smoking
past/quit date_____
present/how much_____
___ stroke
___ swelling of ankles/feet/ legs
___ thyroid disorder
___ tuberculosis
___ ulcers, skin
___ ulcers, stomach
___ varicose veins
___ other: _____

Are you allergic to any of the following?

___ adhesive
___ anti-inflammatories
___ aspirin
___ codeine
___ iodine
___ local anesthetics
___ penicillin
___ shellfish
___ sulfa
___ other: _____
___ None known

Are you pregnant? Y___ N___

Please list any surgeries that you have had:
_____
_____
_____

Please list any medications that you take, including the dosag
_____
_____
_____

Pharmacy Name: _____
Location: _____
Phone No.: _____

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INSURANCE INFORMATION

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to CENTRAL DUPAGE FOOT AND ANKLE SPECIALISTS, INC., for any services furnished to me by that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim(s). If "other health insurance" is indicated on HCFA-1500 form, or elsewhere on any approved claim form or electronically submitted claim, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

Insurance Information

Agreement and Release

I, the undersigned, certify that I (or dependent) have insurance coverage with _____ _____ and assign directly to CENTRAL DUPAGE FOOT AND ANKLE SPECIALISTS, INC., all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor or his staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid for by my insurance.

_____ _____

Responsible Party Signature Date

Relationship: _____

Acknowledgement & Consent to Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. I also consent to have my health information utilized in the manner specified in the Notice except for the following restrictions:

_____ None

_____

_____

_____ _____

Patient Name (please print) Parent or Authorized Representative (if applicable)

_____ _____

Signature Date

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is requested that if you **must cancel** your appointment you provide a 24-hour notice. This will enable another patient who is waiting for an appointment to be scheduled in that time slot.

Office appointments that are cancelled without a 24-hour notice will be charged a $50 fee.

Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW. These appointments will be charged a $50 fee. Patients who no show three (3) or more times may be dismissed from the practice.

The cancellation and no show fees are the sole responsibility of the patient.

Please sign that you have read, understand, and agree to this Cancellation and No Show policy.

_____

Patient Name (Please Print)

_____ _____

Signature of Patient or Patient Representative **Date**