MEDICAL HISTORY

PATIENT NAME	BIRTH DATE	/ /

ALLERGIES (LIST KNOWN ALLERGIES OR REACTIONS TO DRUGS/MEDICATIONS

☐ Penicillin	☐ Sulfa	☐ Local Anesthetic	☐ Anti-inflammatory Medication
☐ Codeine	☐ Tape	☐ Nausea From Anesthetic	☐ Iodine on Skin

MEDICATIONS *(PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER THE COUNTER)*

MEDICATION	DOSE	MEDICATION	DOSE

FOOT/ANKLE PAIN WHERE?	HOW LONG?	MONTHS	YEARS

WHAT PREVIOUS TREATMENT HAVE YOU HAD ON YOUR FOOT/ANKLE?

☐ Surgery	☐ Orthotics	☐ Oral Medications	☐ Cortisone Shots

FAMILY PHYSICIAN INFORMATION

Medical Doctors Name		Phone Number ( ) -	
Street Address	City	State	Zip Code

Have you ever been put to sleep for surgery? ☐ **Yes** ☐ **No**

SHOE SIZE	HEIGHT		WEIGHT
DO YOU DRINK?	☐ NO	☐ YES	DRINKS PER WEEK
DO YOU SMOKE?	☐ NO	☐ YES	PACK(S)/DAY

Indicate which of the following you have had or have at present. Check Yes or No to each item

Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	H.I.V. Positive	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Motion Sickness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Stomach Problems / Reflux / Heartburn	☐ Yes	☐ No
Hepatitis A (Infectious) B (serum)	☐ Yes	☐ No	Ulcers (Diabetic)	☐ Yes	☐ No

I understand the above medical information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

X	/ /
Patient/Guardian Signature	Date

HISTORY REVIEWED BY: DR. SIGNATURE DATE

FINANCIAL POLICY

Thank you for choosing The Podiatry Center as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our billing department at (847) 627-4920. **Your clear understanding of our Financial Policy is important to our professional relationship.**

- WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY; HOWEVER, WE MUST HAVE A COPY OF THE INSURANCE CARD
- IF YOU DO NOT HAVE YOUR INSURANCE CARD WITH YOU, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA/MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CARECREDIT.
- ALL PATIENTS MUST COMPLETE OUR "PATIENT REGISTRATION FORM" AND OTHER RELATED FORMS.
- PLEASE, NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.
- 5 BUSINESS DAYS NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS OR X-RAYS AND THERE MAY BE A NOMINAL FEE.

Self Pay: We expect payment at the time of service unless prior arrangements have been made.

Medicare: We accept Medicare assignment. As a Medicare patient, you are responsible only for the deductible if you have supplemental insurance. A few services and supplies are not covered by Medicare, we will advise you of any non covered charge prior to the service being provided.

HMO/PPO: ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT KNOW YOUR CO-PAY, YOU MAY USE OUR PHONE TO FIND OUT. We are members of most, but not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you will not be billed as long as we have the necessary referrals. Please note: You must have your referral at the time of the visit or your plan requires that we ask you to reschedule. PPO patients will only be responsible for their deductible, co-payments and co-insurance, as long as they have verified with their insurance that our physician is in their plan.

Workers' Compensation: If you are here because of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. Before seeing a doctor, we will require a letter or statement from the Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. (Your employer's human resources office should be able to assist you with obtaining this information.) If payment is not received from these third parties within 90 days, we have the right to bill you directly.

Hospital and Surgery Center Charges: In the event that you undergo surgery in a hospital or ambulatory surgery center, a separate charge will be made by that facility. Your podiatric physician at **The Podiatry Center** may have a financial interest in a surgery center where you will be having your surgery.

MRI Charges: If your podiatric physician orders an MRI you have the right to choose the facility to perform your MRI.

Financial Agreement: I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by my credit card, check or cash. Past due balances may be subject to additional fees.

UCR (Usual and Customary Rates): We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determinations of UCR rates.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services.
If payment is not received from the insurance carrier or other responsible party in 90 days, I will be billed directly.
I will pay unpaid balance by: ____Cash _____Check _____Credit Card ____ CareCredit

______________________ ______________________ ________

Name of Patient (please print) Signature of Patient or Responsible Party Date