Welcome to Skokie Foot & Ankle Specialists, Ltd.

Patient Information

First Name_______________________________________

Last Name_______________________________________

Address____

City__________________ State_________ Zip____________

Birthdate__________________

Gender (circle) Male Female

Marital Status (circle) Single Married Widow Divorced

Spouse/Partner Name________________________________

Your occupation____________________________________

Employer/School____________________________________

Empl/Schl Address__________________________________

How did you hear about us?__________________________

____

Contact Information

Home Phone (_________)____________________________

Work Phone (_________)_____________________________

Cell Phone (_________)_____________________________

Email ____
(for appointment reminders and so you can access your medical history)

In case of emergency, contact:

Name____

- Relationship ___________________________________
- Phone (_________)_________________________________

Financial Information

Who is responsible for this account?_______________________

- Relationship to Patient ________________________________

Insurance cards will be photocopied.

Primary Insurance ______________________________________

- Name of Policy Holder _________________________________
- Birthdate of Policy Holder ______________________________

Secondary Insurance ____________________________________

- Name of Policy Holder _________________________________
- Birthdate of Policy Holder ______________________________

Acknowledgements

My signature below acknowledges that: I give permission to Dr. Steven Miller and staff of Skokie Foot & Ankle Specialists Ltd to diagnose and administer treatment; The information that I have provided is correct to the best of my knowledge; Giving incorrect information can be dangerous to my health; It is my responsibility to inform this office of all changes; I give permission for photographs to be taken; Information may be disclosed to comply with laws requiring or permitting the disclosure or exchange of information; I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for services, and for the purposes of conducting healthcare operations; I hereby authorize the Illinois Department of Insurance to release my personal and private health policy information to Skokie Foot & Ankle Specialists Ltd at the request of the individual; I assign directly to this office and its agents all insurance, Medicare, & Medicaid benefits, if any, otherwise payable to me for services rendered; I authorize the use of my signature on all insurance, Medicare, & Medicaid submissions; I am financially responsible for all charges whether or not paid by insurance; If my account balance becomes overdue and the overdue account is referred to a collection agency, I may be responsible for the costs of collection including reasonable attorney's fees; and I acknowledge having received the "Notice of Privacy Practices".

Signature (of patient or authorized person) ______________________________________ Date ____________________

Please continue on the next page.

MR#	Sig

Print patient's name ____ Today's Date ____________________

Past Medical History

Have you ever had any of the following?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Balance problem
- ☐ Bladder problem
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Cataract
- ☐ Cellulitis
- ☐ Circulatory disorder
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Fainting
- ☐ Gastrointestinal problem
- ☐ Gout
- ☐ Hearing loss
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hepatitis ___
- ☐ HIV or AIDS
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Infection
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine
- ☐ Nerve problem
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Psychological problem
- ☐ Reflux/GERD
- ☐ Seizure
- ☐ Skin disorder
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Transplant
- ☐ Ulcer stomach/skin
- ☐ Varicose veins
- ☐ Vision problem

Other:

Past Surgical History

Please list (with dates):

____

____

____

____

____

____

Review of Systems

Have you had any of the following recently?

- ☐ Fever
- ☐ Nausea or vomiting
- ☐ Blurry vision
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Abdominal pain
- ☐ Painful urination
- ☐ Skin rash
- ☐ Weakness
- ☐ Swelling of legs
- ☐ Significant weight change

Social History

Primary physician ________________________________

Phone ________________________________

Hospital affiliation________________________________

Number of children_________

Special diet?________________________________

Type of exercise________________________________

- Use tobacco? (circle) Yes Never Quit
- Drink alcohol? (circle) Yes Never Quit
- Substance abuse? (circle) Yes Never Quit

Frequency?

Medications

Please list with dose (including over-the-counter & vitamins):

____

____

____

____

____

____

Pharmacy Name ________________________________

Pharmacy Phone________________________________

Family History

Have your siblings, parents, or grandparents ever had:

(please list relationship here)

- ☐ Bunions
- ☐ Hammertoes
- ☐ Flatfeet
- ☐ Ingrown toenails
- ☐ Gout

Please continue on the next page.

MR#	Sig

Print patient's name ______________________________ Today's Date ______________

Allergies

Name of substance:	Name of substance:
Severity: ◻ Mild ◻ Moderate ◻ Severe Which best describes your reaction: ◻ Rash ◻ Itchiness ◻ Diarrhea ◻ Facial or tongue swelling ◻ Dizziness ◻ Difficulty breathing ◻ Upset stomach ◻ Irregular heartbeat ◻ Other:	Severity: ◻ Mild ◻ Moderate ◻ Severe Which best describes your reaction: ◻ Rash ◻ Itchiness ◻ Diarrhea ◻ Facial or tongue swelling ◻ Dizziness ◻ Difficulty breathing ◻ Upset stomach ◻ Irregular heartbeat ◻ Other:
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Check here ◻ if you have no known allergies.

Regarding today's visit:

- What is your foot problem? ______________________________
- Have you been evaluated for this previously? ◻ No ◻ Yes, by ______________________________
- When did this problem begin? ______________________________
- What remedies have you tried so far? ______________________________
- Is this the result of a work-related injury? ◻ No ◻ Yes, claim #______________________________

Thank you for choosing Skokie Foot & Ankle Specialists.

MR#	Sig