

Welcome to Skokie Foot & Ankle Specialists, Ltd.

Patient Information

First Name _____
Last Name _____
Address _____
City _____ State _____ Zip _____
Birthdate _____ Shoe size _____
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 (_____) _____
Check here if you consent to receive automated text and voice messages.

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
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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: _____

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 _____

Past Surgical History

Please list (with dates):

Review of Systems

Have you had any of the following recently?

- Fever Yes No
- Nausea or vomiting Yes No
- Shortness of breath Yes No
- Chest pain Yes No
- Stomach pain Yes No
- Numbness Yes No

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
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Print patient's name _____

Today's Date _____

Allergies

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:

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:

Name of substance:

Severity: Mild Moderate Severe

Which best describes your reaction:

- Rash
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- Other:

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:

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
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