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):

_____

_____

_____

_____

_____

_____

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_____

Review of Systems

Have you had any of the following <u>recently</u>?

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

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:
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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