PLEASE PRINT AND FILL OUT PRIOR TO YOUR APPOINTMENT

PODIATRIC REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age Birthdate

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2. INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

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

_____

Responsible Party Signature

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. 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 my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, 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 only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Relationship Date

3. PHONE NUMBERS

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

E-Mail :

_____

Pharmacy Name & Phone #:

_____

Your PCP Name & Phone #:

_____

Name_____Gender____ Age_____

REASON FOR VISIT

What brings you to the office today?

_____

_____

Please describe any previous treatment and care you have received for this problem

_____

_____

PAIN ASSESSMENT

Indicate your level of pain 1-10 (10 worst pain)
1 2 3 4 5 6 7 8 9 10

_____

Check the symptoms that best describe your problem

Stiffness Pain Instability Swelling
Numbness Other:

Are you symptoms getting....

Better Gradually Better Rapidly
Worse Gradually Worse Rapidly

What improves your symptoms?

Rest Ice Heat Motrin/Aleve
Other:_____

What makes your symptoms worse?

Activity Cold Other: _____

PODIATRY

Do you have any of the following?

Ankle sprain	Enlarged veins	Knee pain	Arch pain
Flat feet	Leg ulcers	Athletes foot	Foot numbness
Loss sensation in feet	Broken ankle	Foot ulcers	Lower back pain
Broken foot bones	Fungal nails	Rash on feet	Bunions
High arch feet	Swelling in ankles	Burning in feet	Heel pain
Swelling in feet	Corn/calluses	Hammer toes	Swelling in legs
Cramps in feet or legs	Ingrown toe nails	Tingling in feet	In-toeing

Do you currently or have ever worn orthotics?
Yes or No
Does your foot pain limit desired activity?

LIFESTYLE FACTORS

Have you ever smoked?
Yes or No # of years ____# of packs____
Do you smoke now?
Yes or No
Do you use recreational drugs?
Yes or No Types_____ # time/week_____
How much alcohol do you drink per week?
drinks per week_____
How much caffeine do you drink per day?
drinks/ day_____
How often do you exercise?
times/week_____
How many hours a day do you stand?
# of hours_____
What type of shoes do you wear?
Flat heels boots loafers oxfords
Sandals sneakers Other:_____

Hospitalization & Surgeries

Reason_____Date_____
Reason_____Date_____

Current Medications

Are you currently taking blood thinners?
Yes or No
What medications are you currently taking?
Name_____Dosage_____Frequency_____
Name_____Dosage_____Frequency_____

ALLEGIES

Are you allergic to any of the following?
Adhesive tape antibiotics latex aspirin
Barbiturates(sleeping pills) Iodine Codeine
Sulfa Local Anesthetics Other:_____
Do you have any other allergies?
Name_____Reaction_____
Name_____Reaction_____

Name_____ Date of appointment_____

Past Medical History:

Have you ever had any of the following?

Alcoholism	Bleeding Disorder	Epilepsy	Joint disorder	Polio
Allergies	Blood Disease	Glaucoma	Kidney disorder	Rheumatic Fever
Anemia	Blood Transfusion	Gout	Liver disease	Stroke
Anxiety Disorder	Cancer	Heart Disease	Lung disease	Skin disorder
Arthritis	Diabetes	Heart Problems	Measles	Stomach Ulcer
Asthma	Depression	Hepatitis A, B or C	Migraines	Substance abuse
AIDS/HIV	Ear Problems	High Blood Pressure	Osteoporosis	Thyroid Disorder
Back Problems	Eating Disorder	High Cholesterol	Pneumonia	Tuberculosis

Family History

Has anyone in your family ever had any of the following conditions?

Alcoholism	Bleeding Disorder	Heart Disease	Migraines
Allergies	Blood Disorder	Hepatitis	Psychiatric Disorder
Alzheimer's	Cancer	High Cholesterol	Osteporosis
Anemia	Depression	High Blood pressure	Stroke
Anxiety	Diabetes	Joint Disorder	Substance Abuse
Arthritis	Epilepsy	Kidney Disease	Thyroid Disorder
Asthma	Genetic Disorder	Liver Disease	
AIDS/HIV	Glaucoma	Lung Disease	
Details:			

Women Only

Are you pregnant?	**Are you breastfeeding?**
Yes or no	Yes or no

How did you find out about us?/ Como se enteraron de nosotros?

- Paper advertising/ name of the newspaper/ Anuncio en Perodico/ Qual?_____
- Radio/Radio_____
- Referred by friend/ Referido por Amigo_____
- Referred by DR./ Referido por Medico_____
- Other/Otro_____

_____ _____

Your Name/ Su nombre Date/ Fecha

Your help is appreciated. Thank You for your feedback/ Le agradecemos por su ayuda.*

ILL FOOT & ANKLE CLINIC
1400 E. Golf Rd., Suite201
Des Plaines, IL 60016
Tel. (847)298-3338
Fax (847)298-3334

HIPAA POLICY AND ASSIGNMENT OF BENEFITS

PATIENT NAME_____

Address:

Phone #:

PRIVACY POLICY: I acknowledge having received the Practice's "Notice of Privacy Practices". My rights including the right to send toy record, to limit disclosure of my health information, and to request and amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Dr.Alexander Yanovskiy DPM and all physicians, employees or designees have already made disclosures with my prior consent.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the health care operations of Dr.Alexander Yanovskiy DPM and all physicians, employees or designees. I authorize the release of any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Dr.Alexander Yanovskiy DPM and all physicians, employees or designees may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE:
I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to Dr.Alexander Yanovskiy DPM and all physicians, employees or designees for any covered or non-covered services, as defines by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees.

X_____ _____ _____
Patient or Authorized Signature Relationship Date

_____ _____
Witness Signature Date

ILL FOOT & ANKLE CLINIC

1400 E. Golf Rd., Suite 201
Des Plaines, IL 60016
Ph.847-298-3338

Dear Patients,

Please note we reserve the right to charge $**25.00** fee for all missing (failed) appointments without 24 hour notice.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____Date: _____

ILL FOOT AND ANKLE CLINIC
1400 E. Golf Rd.
Suite 201
Des Plaines, IL 60016

Credit Card on File Agreement

You are giving ILL Foot and Ankle Clinic permission to automatically charge your credit card on file for your outstanding balances or any other patient(s) balances you have listed on this form at time of service.

I authorize ILL Foot and Ankle Clinic to charge co-pays and outstanding balances on my account to the following credit card:

Visa_____ MasterCard_____ Discover_____

Credit Card Holder's Name: _____ (Please Print)

Credit Card # _____

Expiration Date: _____ Security code _____

Co-pays: Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill or any other patient(s) you have listed on this form and there is still an outstanding balance owed, ILL Foot & Ankle Clinic will notify you via mail. If the balance owed is not paid within 30 days ILL Foot & Ankle Clinic, will charge the balance to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

This credit card on file is to be used for the following patient(s), please print name(s) below: (expires after 1 year)

Patient Full Name: _____ DOB: ____ / ____ / _____
Patient Full Name: _____ DOB: ____ / ____ / _____
Patient Full Name: _____ DOB: ____ / ____ / _____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed above. This agreement will expire for multiple users on an annual basis. If continued authorization is requested, another credit card agreement can be issued or a manager can verbally authorize and document the extension of an agreement.

Signature: _____Date: _____

Waiver of Claims, Informed Consent and Release from Liability for Patients

Patient_____

The Parties understand, accept and agree to all terms, conditions and provisions of this Agreement on the date Patient indicates acceptance of this Agreement by signature on the document.

I, the undersigned Patient, accept, understand and agree to the following terms, provisions and conditions:

1. I, _____ hereby waive and release, indemnify, hold harmless and forever discharge _____ and its agents, participants, employees, officers, directors, affiliates, successors, members, trustees, managers and assigns, of and form any and all claims, demands, debts, contracts, expenses, causes of action, lawsuits, damages and liabilities, of every kind and nature, whether known or unknown, in law or equity, that I ever had or may have, arising from or in any way related to the procedures and care being provided to me.
2. I understand that care and service being provided to me may be inherently dangerous and can cause serious or grievous injuries, including bodily injury, damage to personal property, and/ or me. On behalf of myself, my heirs, assigns and next kin, I waive all claims for damages and injuries sustained to me or my property that may have against the aforementioned parties.
3. By this Waiver, I assume any risk, and take full responsibility and waive any claims for personal injury, death or damage to personal property associated with procedures and services provided.

This Agreement represents the complete and entire agreement between the parties to it. No prior written or electronic agreement, verbal communication or verbal agreement may be offered or used to alter any terms or conditions of this Agreement; nor shall such extrinsic agreements be effective or binding between the parties regarding any term or condition of this Agreement or be offered or introduced to show intent of a party to any matter pertaining to this Agreement.

I have read and understand, and fully agree with the content of the Waiver and Release. I understand and confirm by signing Waiver and Release.
I am at least 18 years and legally able to sign the Waiver and Release.

Date_____

Name Printed_____

Signature_____