Instep Podiatry, P.C.

Foot and ankle specialists and surgeons

200 East Willow Avenue, Lower Level, Wheaton, Illinois 60187

REGISTRATION
(PLEASE PRINT)

Date _____ Home Phone _____
Cell Phone _____
Email Address _____

Patient _____
Last Name First Name Initial

Responsible Party (if a minor) _____
Street Address _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient Employed By _____
Business Address _____
Occupation _____ Business Phone _____
Spouse (or responsible party) Name _____Birthdate _____
Business Name and Address _____
Occupation _____ Business Phone _____
Who is responsible for this account? _____Relationship to Patient _____
Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐ No ☐ Yes If yes,
Name of Primary Insurer _____
Contract # _____ Group # _____ Subscriber # _____
Name of Secondary Insurer (if any) _____
Contract # _____ Group # _____ Subscriber # _____

In case of emergency, who should be notified? _____Phone _____
How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. _____ all medical 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 my insurance submissions.

_____ _____
Signature of Insured/Guardian 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.

_____ _____
Beneficiary Signature Date

New Patient Podiatric History Form

Dr. Lisa K. Rechkemmer
Dr. Frank H. Russo

Instep Podiatry, PC
200 E. Willow Ave.
Wheaton, IL 60187
630.462.1470

Please Print

Patient Name_____Date_____

Age_____ Height_____Weight_____Shoe Size_____

Primary Care Physician_____

Pharmacy Name and Address_____

Chief Complaint *(Nature of your foot pain or problem)*_____

_____

Location on foot or leg:
Check all that apply

__ Forefoot/Toes __Middle Foot __ Back Part of Foot
__Ankle __Top __ Bottom
__Outer Side __Inner Side

How long has this bothered you? _____
How did this begin? _____
What course has it taken? _____
What aggravates it? _____
What makes it feel better?_____
What have you done to relive the condition? _____
_____
(If you have seen another doctor to relieve the pain, please give his/her name)
_____

Please list the prescriptions that you take:_____
_____
_____
_____
_____
_____

Are you using any over the counter medications?_____
If so, which ones *(names)*?_____
_____
_____

Please turn this paper over and complete the questions on the back

08.03.11

General Health: *If you have had or have any of the following, check all that apply:*

__ Hip problems
__ Ankle problems
__ Shingles
__ Skin problems
__ Bone fracture
__ DVT or Blood clot
__ Pneumonia
__ Headaches
__ Bruise easily
__Neck pain
__ Lower back pain
__ Pain, cramps, swelling, tingling
__ Burning or numbness in feet
__ Burning or numbness in legs
__ HIV
__ Shortness of breath

Can you take aspirin?_____

Have you had a local anesthetic *(such as dental work)*?_____

Did you have any problems with it?_____

Do you smoke?_____How much?_____For how long?_____

Do you drink?_____How much?_____For how long?_____

Past surgeries or hospitalizations: _____

_____

_____

Allergies

Are you allergic or sensitive to (***please circle severity and describe what type of reaction***):

__ I am not allergic to anything that I know of.

__Penicillin *(Mild, Moderate, Severe)* _____

__Novocain *(Mild, Moderate, Severe)* _____

__Anesthetics (*Mild, Moderate, Severe)* _____

__Codeine *(Mild, Moderate, Severe)* _____

__Iodine *(Mild, Moderate, Severe)* _____

__Sulfa *(Mild, Moderate, Severe)* _____

__Metal *(Mild, Moderate, Severe)* _____

__Adhesive Tape *(Mild, Moderate, Severe)* _____

__Drugs:_____

Family Health

(Please circle M for Mother and F for Father)

Have you or any of your family members ever had any of the following *(please check all that apply)*

You	Family		You	Family	
___	M/F	Diabetes	___	M/F	Epilepsy
___	M/F	Heart trouble	___	M/F	Nerve disease
___	M/F	High blood pressure	___	M/F	Muscle disease
___	M/F	Bleeding problems	___	M/F	Bone disease
___	M/F	Kidney trouble	___	M/F	Varicose veins
___	M/F	Liver problems	___	M/F	Arthritis
___	M/F	Anemia	___	M/F	Cancer
___	M/F	Lung disease	___	M/F	Asthma
___	M/F	DVT or Blood clot	___	M/F	Gout

I certify that the above information is accurate and true to the best of my knowledge.

Signature:_____ **Date:**_____