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

PATIENT RESPONSIBILITY FORM

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.

Co-payments are due at time of service.

In the event that my health plan determines a service to be "not payable", To **Instep Podiatry, PC** I will be responsible for the complete charge and agree to pay the costs of all services provided.

If I am uninsured, I agree to pay for the medical services rendered to me By **Instep Podiatry, PC** at the time of service.

____

Signature of Patient, Authorized Representative or Responsible Party

____

Print Name of Patient, Authorized Representative or Responsible Party

____

Date

Podiatric History Form

Dr. Frank H. Russo
Dr. Maliha S. Khan

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 relieve the condition? ____________________________

____

(If you have seen another doctor to relieve the pain, please give his/her name)

____

Please list the prescriptions that you take and the dosage: ____________________

____

____

____

____

____

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

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 <u>Mother</u> and *F* for <u>Father</u>)

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

YOU	Family	
___	M/F	Diabetes
___	M/F	Heart trouble
___	M/F	High blood pressure
___	M/F	Bleeding problems
___	M/F	Kidney trouble
___	M/F	Liver problems
___	M/F	Anemia
___	M/F	Lung disease
___	M/F	DVT or Blood clot

YOU	Family	
___	M/F	Epilepsy
___	M/F	Nerve disease
___	M/F	Muscle disease
___	M/F	Bone disease
___	M/F	Varicose veins
___	M/F	Arthritis
___	M/F	Cancer
___	M/F	Asthma
___	M/F	Gout

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

Signature:____________________ **Date:**____________

Appointment Cancellation/No Show Policy

Our goal is to provide quality individualized medical care in a timely manner. "No Shows" and late cancellations inconvenience those individuals who are in need of medical treatment. We would like to inform you of our office policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please call Instep Podiatry promptly if you need to cancel or reschedule your appointment. We require that you call twenty-four (24) hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to receive medical care in a timely manner.

As a courtesy, our staff will call you in advance to confirm your appointment. We will leave a voice mail message if we are unable to reach you personally. If you are not able to keep your appointment, we will be happy to reschedule it for you. Please do give us a 24-hour notice to cancel or reschedule.

No Show Policy

A "No Show" is someone who is not present at the time of his or her scheduled appointment and has not provided adequate notification. We understand that emergencies may occur, however, when you do not call to cancel an appointment, you are preventing another patient from getting much needed treatment.

Charge for Late Cancellations and No Show's

Failure to give a 24-hour advance cancellation or being a "No Show" will result in a non-refundable administrative charge of $40.00. This fee will not be covered by your insurance company.

If you have any questions regarding this policy, please ask our staff and we will be glad to clarify your questions. We thank you in advance for your cooperation and understanding.

Appointment Cancellation/No Show Policy

I acknowledge that I have been presented with the Appointment Cancellation/No Show Policy and that I understand the policy.

________________________________ Print Name

________________________________ Signature _______ Date