# PERFORMANCE FOOT AND ANKLE CENTERS, LLC

401 E. 162nd St., Suite 101 • South Holland, IL 60473
Phone: 708-596-3757 • Fax: 708-596-3779

15300 West Ave., Suite 210, Orland Park, IL 60462
Phone: 708-873-9440 • 708-873-2128

## ADULT PATIENT REGISTRATION FORM

**Referred By:** ☐ Physician: (Name) ☐ Patient: (Name) ☐ Other: (how)

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | MI: | Last Name: | Marital Status: S M W D Sep |
| Address: | City: | ST: | Zip: |
| Date of Birth: | Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | | Gender: M or F Age:_____ |
| Home Phone: | Cell Phone: | Work Phone: | |

Prefered Method of Contact (Please circle one): Home Phone Cell Phone

| | |
|---|---|
| Email: | Occupation: |
| Employer: | Employer Phone: |

| | | | |
|---|---|---|---|
| Employer Address: | City: | St: | Zip: |

## SPOUSE/SIGNIFICANT OTHER/EMERGENCY CONTACT

| | | | | | |
|---|---|---|---|---|---|
| First Name: | MI: | Last Name: | | SS # ___ __ ___ - __ ___ - __ __ ___ __ | |
| Address: | City: | ST: | Zip: | DOB: | |
| Home Phone: | Cell Phone: | Employer: | | Phone: | |

| | |
|---|---|
| Do you authorize this office to discuss your care or treatment with any party besides yourself? | ☐ YES ☐ NO |
| Authorized Persons: | |

| | | | |
|---|---|---|---|
| May we leave messages on your phone? | ☐ YES ☐ NO | Preferred Contact Phone | ☐ Home ☐ Cell ☐ Work |
| Emergency Contact:_____ | Relationship:_____ | Phone:_____ | |

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Primary Insurance: | Identification # | | Group # |
| Policy Holder's Name: | Date of Birth: | Relationship: | |
| Secondary Insurance: | Identification # | | Group # |
| Policy Holder's Name: | Date of Birth: | Relationship: | |

## WORKER'S COMPENSATION INFORMATION

| | | | |
|---|---|---|---|
| Worker's Comp Carrier: | Date of Injury: | Claim # | |
| Case Manager: | Phone: | Fax: | |
| Address: | City: | ST: | Zip: |

## AUTHORIZATIONS

- I hereby authorize release of medical information for insurance claim purposes and to other healthcare professionals involved in the treatment of care
- I hereby authorize payments of my medical benefits to go to Performance Foot and Ankle Center, LLC
- I understand that I am responsible for any portion of my bill not covered by my insurance company
- I understand that if the account is not paid in full I will be sent to collections.
- I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the notice
- I understand all of the above and herby state that the information is correct to the best of my knowledge.

Signed: _____ Date: _____
Signature of Patient or Authorized Representative (Month/Day/Year)

**Patient Complaint**

Patient Name:_____ Date:_____

What is the reason for today's visit?_____

Location of Problem:_____ How long has this bothered you?:_____

Circle how painful: **Mild Moderate Severe**

Circle how often: **Occasionally Daily At Night Walking Running Constantly**

What caused the problem?_____

Was there trauma or any other aggravating factors?_____

Does anything else occur with this problem? YES NO (if yes, please explain) _____

_____

**Review of Systems** (please check all that apply)

**Constitutional** ☐ Fatigue/Weakness ☐ Fever ☐ Good General Health

**Eyes** ☐ Eye Disease/Retinopathy ☐ Eye Inflammation ☐ Eye Injury ☐ Eye Strain ☐ Vision Problems

**Ears, Nose & Throat** ☐ Bad Breath/Bad Taste in Mouth ☐ Bleeding Gums ☐ Dental Problems ☐ Ear Discharge ☐ Ear Noises ☐ Hearing Loss ☐ Hoarseness ☐ Mouth Sores ☐ Nose Bleeding ☐ Nose Discharge ☐ Sinus Problems ☐ Sore Throat ☐ Speech Difficulty

**Cardiovascular** ☐ Chest Pain ☐ Extremities are Cold ☐ Feet/Ankle Swelling ☐ Hands Swell ☐ Heart Attack ☐ Heart Problems ☐ High Blood Pressure ☐ Leg Pain Walking ☐Low Blood Pressure ☐ Night Sweats ☐ Pain Over Heart ☐ Rapid Heart Beat ☐ Stents in Heart/Legs ☐ Varicose Veins ☐ Vascular Grafts

**Genitourinary** (Urogenital) ☐ Blood in Urine ☐ Difficult Urination ☐ Discolored Urine ☐ Frequent Urination ☐ Incontinence or Leakage ☐ Kidney Stones ☐ Painful Urination ☐ Prostate Trouble

**Gastrointestinal** ☐ Abdominal Pain ☐ Appendicitis ☐ Black Stool ☐ Bloody Stool ☐ Constipation ☐ Diarrhea ☐ Difficult Chewing ☐ Difficult Swallowing ☐ Excessive Hunger ☐ Flatulence ☐ Gallbladder Trouble ☐ Hemorrhoids ☐ Indigestion ☐ Nausea ☐ Poor Appetite ☐ Stomach Trouble ☐ Ulcers ☐ Vomiting Food ☐ Weight Gain ☐ Weight Loss

**Nervous System** ☐ Brain Disease ☐ Convulsions ☐ Dizziness ☐ Fainting ☐ Forgetfulness ☐ Headaches ☐ Loss of Feeling ☐ Muscle Jerking ☐ Numbness/Tingling Sensations ☐ Paralysis ☐ Seizure ☐ Spine Disease ☐ Stroke ☐ Weakness

**Respiratory** ☐ Allergies ☐ Asthma ☐ Bronchitis ☐ Coughing Blood ☐ Coughing Phlegm ☐ Difficult Breathing ☐ Emphysema ☐ Lung Problems ☐ Persistent Cough ☐ Shortness of Breath/Wheezing

**Integument** (Skin) ☐ Abrasions ☐ Bruises ☐ Deformed Nails ☐ Discoloration /Change in Skin Color ☐ Eczema ☐ Hives ☐ Itching ☐ Moles ☐ Psoriasis ☐ Skin Cancers ☐ skin Rash ☐ Ulcerations

**Musculoskeletal** (Muscles/Skeleton) ☐ Arthritis ☐ Back Pain ☐ Bursitis ☐ Difficulty Walking ☐ Fractures ☐ Joint Implants ☐ Joint Pain ☐ Joint Swelling ☐ Lumbago ☐ Muscle Pain ☐ Sciatica ☐ Scoliosis ☐ Sprains ☐ Stiffness ☐ Muscle Weakness

**Hematologic/ Lymphatic** ☐ Anemia ☐ Bleeding Disorder ☐ Easily Bleeds ☐ Easily Bruises ☐ Enlarged Glands ☐ Jaundice ☐ Past Transfusion ☐ Phlebitis ☐ Slow to Heal After Cuts ☐ Take Aspirin ☐ Take Coumadin

**Psychiatric** ☐ Confusion ☐ Depression ☐ Memory Loss/Alzheimer's ☐ Nervousness ☐ Sleep Problems

**Endocrine** ☐ Change in Hat Size ☐ Cold Intolerance ☐ Diabetes ☐ Dry Skin ☐ Excessive Thirst ☐ Excessive Urination ☐ Glandular Problems ☐ Heat Intolerance ☐ Hormone Problem ☐ Thyroid Disease

## Patient History

Height_____ Weight_____ Shoe Size_____ Occupation _____

Ethnicity (please circle one): **Hispanic/Latino** **Not Hispanic/Latino** **Unknown** **Decline**

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Unknown
- ☐ White
- ☐ Decline to Answer

Preferred Language:_____

Do you have **diabetes**? ☐ YES ☐ NO **If yes**,do you take?: ☐ Insulin ☐ Pills ☐ Both insulin and pills
☐Have diabetes, but it is controlled through other means

Any past foot/ankle problems? ☐ **Yes** ☐ **No**
☐ Bunionectomy ☐ Hammertoe ☐ Ruptured Arch
☐ Arthrodesis ☐ Toe Amputation ☐ Implant ☐ Other_____

Do you have any artificial joints? ☐ **Yes** ☐ **No**
☐ Hip ☐ Elbow ☐ Knee ☐ Shoulder ☐ Other_____

What type of shoes do you normally wear? (please check all that apply)
- ☐ Athletic sport shoes
- ☐ Casual footwear with no heel
- ☐ Diabetic shoes
- ☐ Dress shoes
- ☐ Flip-flops
- ☐ High heels
- ☐ Sandals
- ☐ Steel toed boots
- ☐ Work/hiking shoes

Do you get pedicures? ☐ **Yes** ☐ **No**
If yes, how often? ☐ 1-6 times per year ☐ Once Per Month ☐ More Than Once a Month

Do you use any type of foot treatments at home? ☐ **Yes** ☐ **No**
If yes, what kind?_____

## Social History

Employment Type: ☐ Sits at Job ☐ Sits/Stands/Walks ☐ Stands at Job ☐ Stands and Walks
☐ Retired/Unemployed ☐ Sits and Stands at Job ☐ Student ☐ Other_____

Do you smoke? ☐ **Yes** ☐ **No** ☐ **Former Smoker** ☐ **Never Smoked**
How much do you smoke per day? ☐ 1-5 cigarettes per day ☐ less than 5 cigarettes per week
☐ 1/2 pack per day ☐ 1 pack a day ☐ more than one pack a day
Do you use: ☐Chewing Tobacco ☐ Cigarettes ☐ Cigars
How many years? ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ over 20 years

Do you drink alcoholic beverages including wine, beer or hard liquc ☐ **Yes** ☐ **No**
If yes, alcohol quantity is: ☐ Rarely ☐ 1-2 per week ☐ 1-2 per day ☐ 3 or more per day

Do you use illicit drugs? ☐ **Yes** ☐ **No**
If yes, which ones? ☐ Cocaine ☐ Heroine ☐ Marijuana ☐ Methamphetamine

Are you currently Pregnant? ☐ **Yes** ☐ **No** If yes: ☐ 1st (1-3 months) ☐ 2nd (4-6 months ☐ 3rd (7-9 months)

Marital Status? ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed ☐ Have a domestic partner

Do you have children ☐ **Yes** ☐ **No** If yes, how many? _____

Current living situation? ☐ Live alone ☐ Live w/family ☐ Live w/Spouse in your own home ☐ Skilled Nursing Home
☐ Retirement community ☐ Assisted Living ☐ Community Shelter ☐ Home for the Disabled ☐ Homeless

Do you have stairs in your home ☐ **Yes** ☐ **No** If yes, how mar ☐ 1-4 ☐ 1-10 ☐More than 10

Do you exercise? ☐ **Yes** ☐ **No** If yes, how many times per week? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 days a week

## Patient/Family History

**Please check ALL illnesses or conditions that apply to you or your family:**

| Me | Family | | Me | Family | |
|---|---|---|---|---|---|
| ☐ | ☐ | **No Known Medical History** | ☐ | ☐ | Heart Disease/Heart Attack |
| ☐ | ☐ | Aids/HIV | ☐ | ☐ | Hypertension |
| ☐ | ☐ | Allergies | ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Amputation | ☐ | ☐ | Lymphedema |
| ☐ | ☐ | Sickle Cell | ☐ | ☐ | Neurological Problems/Neuropathy |
| ☐ | ☐ | Anemia | ☐ | ☐ | Obesity |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | Bleeding/Bruising | ☐ | ☐ | PAD/Peripheral Vascular Disease |
| ☐ | ☐ | Cancer | ☐ | ☐ | Skin Disease |
| ☐ | ☐ | Congenital Abnormalities | ☐ | ☐ | Stroke |
| ☐ | ☐ | Depression | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Ulcers |
| ☐ | ☐ | DVT/Blood Clots | ☐ | ☐ | Vascular or Bypass Surgery |
| ☐ | ☐ | Foot Problems | ☐ | ☐ | Other_____ |
| ☐ | ☐ | Goiter/Thyroid | | | |

## Surgeries

Have you had any previous surgeries?

If YES please list below:

_____

_____

_____

_____

## Allergies

☐ No known allergies
☐ Anesthetics
☐ Codeine
☐ Iodine
☐ Latex
☐ Narcotics
☐ Penicillin
☐ Sulfa
☐ Tape
☐ Other (please list below)

_____
_____
_____
_____
_____
_____

## Medication and Dosage

☐ **No Medication at this time**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

use back of this form if more room is needed

## Pharmacy Information

_____

Pharmacy Name

_____

Address

_____

City, State, Zip

_____

Phone Number

_____

Fax Number

_____

## Primary Care Physician

_____

Name

_____

Address

_____

City, State, Zip

_____

Phone

_____

Fax

## FINANCIAL POLICY OF PERFORMANCE FOOT AND ANKLE

Thank you for choosing Performance Foot and Ankle as your foot care provider. We are committed to providing you with quality and affordable health care. Please read the following office payment policy and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

**Insurance.** We participate in most insurance plans, including Medicare. It is your responsibility to know if we are a participating provider in your health plan. If you are not insured by a plan we participate in or your insurance is not active at the time of service, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**Co-Payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Prior to providing new service, unpaid balances must be paid or payment arrangements must be approved by the office manager.

**Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your service.

**Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or state ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information you will be responsible for the balance of the claim. If required, obtaining the proper referral from your Primary Care Physician is your responsibility. A patient presenting to our office without a valid referral will be asked to pay in full.

**Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

**Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate charges to help you receive your maximum benefits.

**Non payment.** Statements are sent out every 30 days. Your prompt payment will assist us in keeping the cost of healthcare down Partial payments will not be accepted unless otherwise approved by the office manager. If the account is not paid in full by 91 days, the account will be charged a late fee and the account will be sent to a collection recovery program. Please be aware that if a balance remains unpaid you will receive notice of the pending collections process. At that time we will refer your account to a collections agency or small claims court and you and your family members may be discharged from the practice. Once your account has been placed into the collection process you have 30 days to find alternative podiatric care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

.

**Missed appointments.** Our policy is to charge $25.00 for missed appointments not cancelled within 24 hours prior to the appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. More than 3 no-show appointments may result in termination of care for non-compliance.

**Refunds**. Overpayments will be refunded to the appropriate party. Patient refunds will not be provided until all active and past due accounts are paid in full. Patient credits under $35.00 will be reinstated upon patient's return unless specifically requested.

**Fees.** Our fees are representative of the usual and customary charges for our area. An additional fee of $25.00 will be added for each returned check claiming non sufficient funds.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party Date