PATIENT INFORMATION

DATE: ____________________________

NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____ __________
NUMBER STREET APT. CITY STATE ZIP

HOME PHONE: ___________________________ WORK PHONE: ____________________________ CELL PHONE: __________________________________

EMAIL: ____DATE OF BIRTH: ________________________ GENDER: _____ MALE _______ FEMALE

MARITAL STATUS: __________________________ SS# _________-___________-____________

EMPLOYER NAME/ADDRESS: ____

PRIMARY CARE DOCTOR: ____
Name, Address & Phone Number

PREFERRED PHARMACY: ____
Name, Address & Phone Number is **Required**

PRIMARY LANGUAGE: ____________________ ETHNICITY: _______ HISPANIC OR LATINO ________ NOT HISPANIC OR LATINO

RACE: ____ AMERICAN INDIAN OR ALASKAN NATIVE ______ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
____ ASIAN ______ BLACK OR AFRICAN AMERICAN _____ WHITE

How did you hear about us: _____ Primary Care Doctor _____Internet (Please Circle): Google, Yahoo, Bing, Yelp or other
_____ Insurance Website/Insurance Carrier _____Friend/Family _____Other: ___________________________

FINANCIALLY RESPONSIBLE PERSON

NAME: _________________________________ RELATION TO PATIENT: ____________________PHONE: ____

ADDRESS: ____EMAIL: ____

EMPLOYER NAME/ADDRESS: ____

OTHER PERSON TO NOTIFY IN EMERGENCY: __________________________________ PHONE# _____________________________________

MEDICAL INSURANCE COVERAGE

NAME OF PRIMARY INS. CO. ____
ID/POLICY# ____ GROUP#: ____
POLICY HOLDER NAME: ________________________________ D.O.B.: ____
RELATIONSHIP TO HOLDER: _______SELF ______SPOUSE _____GUARDIAN

NAME OF SECONDARY INS. CO. ____
ID/POLICY# ____ GROUP#: ____
POLICY HOLDER NAME: ________________________________ D.O.B.: ____
RELATIONSHIP TO HOLDER: ________SELF ________SPOUSE _______GUARDIAN

I understand and acknowledge that I am personally responsible for the services rendered at this facility. Lakeforest Foot and Ankle Center will bill my insurance as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

____
SIGNATURE OF SUBSCRIBER OR BENEFICIARY DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Practices and that I have read (or had the opportunity or read if I so chose) and understood the Notice**.**

____
PRINT NAME OF PATIENT OR LEGAL GUARDIAN DATE

LAKEFOREST FOOT AND ANKLE CENTER
DRS. TABOR AND WEBER, PA

FINANCIAL POLICY

NEW INSURANCE

Please notify us immediately if your insurance has changed.

COPAYMENT

Please know that all copayments are due at the time of your appointment.

COMPLETION OF FORMS

All forms to be completed by medical staff members will be subject to a **$15 charge** that will be paid at the time the form is submitted.

NO SHOW/ CANCELATION FEE

If you miss your scheduled appointment without notifying our office within 24 hours or reschedule the same day, a **$25 charge** will be added to your account.

RETURNING CHECK FEE

$50.00 charge for all returned checks

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage with

______________________________ and assign directly to Drs. Tabor and Weber, PA all insurance benefits, payable to me for services rendered. I understand that I am responsible for all information necessary to secure payment of benefits. I authorize **RELEASE OF MEDICAL INFORMATION** to my insurance carrier, any third party as it materially relates to services provided or requested by physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Signature: ____

Printed Name: ____ Date: ______/______/_________

Name: ____________________________________ Height: ___________ Weight: ____________ Shoe Size: __________

What is the reason for your visit today? ____

When did your symptoms start? ____

What medical problems do you have or are you being treated for? Please circle all that Apply:

Alcoholism	Depression	Kidney infections
Allergies/Hayfever	Diabetes Type 1	Kidney Stone
Anemia	Diabetes Type 2	Migraine
Anxiety	Epilepsy	Multiple Sclerosis/MS
Asthma	Fracture	Obesity
Atrial Fibrillation	Gastric Ulcer	Old MI/ Heart Attack
Blood Transfusions	Gastrointestinal Disease	Osteoarthritis
CAD/Heart Disease	GERD/Acid Reflux	Osteoporosis
Cancer	Gestational Diabetes	Pneumonia
Cardiac Pacer	Glaucoma	Progressive Neurological Disorder
Cardiovascular Disease	Heart Murmur	Pulmonary Disease/Lung Problems
Heart Failure/CHF	Hepatitis	Rheumatic Fever
Cirrhosis	High Cholesterol	Rheumatoid Arthritis
Colitis	Hyperlipidemia	Sexually Transmitted Disease/STD
COPD	Hypertension/High Blood Pressure	Terminal Illness
CRF/Kidney Failure	Hyperthyroidism	Thyroid Disease
Crohn's Disease	Hypothyroidism	TIA/Mini-Stroke
CVA/Stroke	Insulin Pump	Tuberculosis/TB
DVT/Clot	Joint Pain	Valvular Problems

Other Medical History: ____

Please list any operations you have ever had: ____

____

Please list all medications you are currently taking including Strength:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Please list any allergies to medications:

Name: ______________________________________ Reaction: ______________________________________

Name: ______________________________________ Reaction: ______________________________________

Name: ______________________________________ Reaction: ______________________________________

Family History (Please Circle)

Alcoholism	Congenital Anomaly	Hypertension/High Blood Pressure
Anemia	COPD	Hypothyroidism
Anxiety	Crohn's Disease	Kidney Disease
Asthma	Depression	Liver Disease
Birth Defects	Diabetes	Multiple Births
CAD/Heart Disease	Epilepsy	Osteoarthritis
Cardiovascular Disease	GERD/Acid Reflux	Osteoporosis
CHF/Heart Failure	Hypercholesterolemia	Pulmonary Disease
Cancer: _________________	Hyperlipidemia	Stroke

Smoking Status: ____ Current every day smoker _____ Current some day smoker

____ Former smoker _____ Never smoker

Tobacco Use: ________YES ________ NO

Alcohol Use: ____ Non-Drinker ___ Occasional Drinker ____ Social Drinker ____ Heavy Drinker ____ Recovery Alcoholic

Do you frequently experience, or have you recently experienced any of the following symptoms? Please Circle:

Weight change (gain or loss)
Fever
Chills
Feeling tired or poorly
Weakness

Rapid or irregular heartbeat (palpitations)
Chest pain
- Cold hands and feet
- Calf pain while walking

Cough
Wheezing
Difficulty breathing
Shortness of breath

Poor appetite
Light-colored bowel movement
Nausea
Vomiting
Diarrhea
Abdominal pain
Abnormal liver function tests

Arthritis
Back pain
Joint pain
- Gout
- Muscle aches
- Muscle cramps

Seizures
Weakness
Numbness
- Tingling sensation
- Burning sensation

Rash
Itching
Dry skin
Cysts or other masses under skin
- Bruising
- Hives
- Flushing
- Skin bump (small or large)

I certify that the above information is true and correct to the best of my knowledge. I give permission to Drs. Tabor, Weber and Nagorski to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

____ ________________________________

Signature of patient or legal guardian Date

Medical Information Release Form

Name: ___________________________ Date of birth: ______/_______/_______

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to (**please provide first and last name**):

[ ] Spouse ____________________________

[ ] Child(ren)__________________________

[ ] Other_____________________________

[ ] Information is not to be released to **anyone.**

The ***release*** of this information will remain in effect until terminated by me in writing

Signed: _________________________ Date:____/____/______