Welcome to the Lake Zurich Foot Clinic

Patient Information

Name _____

How do you wish to be addressed? _____

Address _____

City _____State__ Zip_____

Date of Birth_____Age_____

Gender _____ Marital Status _____

Email Address_____

Employer/Student Status _____

Occupation_____

How did you hear about us? _____

What is your ethnicity? Non-Hispanic Hispanic
What is your race? _____

Phone Numbers

Home_____

Cell _____

Work _____

Reminder Preference (Please Circle) Call/Text/Email

Emergency Contact

Name_____

Relationship_____

Phone _____

Insurance

Financially Responsible Party _____

Relationship _____

Address and phone if different from patient

_____

_____

Primary Insurance Co. _____

Subscriber Name _____

Subscriber Birthdate _____

Secondary Insurance Co. _____

Subscriber Name _____

Subscriber Birthdate _____

Podiatric History

What is your chief complaint regarding your feet, ankles, or legs? _____

_____

Is this a work-related condition? _____

Duration of current problem_____

Have you been treated by another podiatrist? _____

If yes, what were you treated for?_____

_____

Last treatment date _____

I hereby give consent for the doctors at the Lake Zurich Foot Clinic to treat me. I agree to accept financial responsibility for all charges incurred. I also assign the Lake Zurich Foot Clinic all benefits provided by my insurance company for services rendered. I authorize the release of any medical or other information necessary to process my claim. I acknowledge that I have been informed of the Practice's Financial and HIPAA policy.

Signature: _____Date _____

Primary Care Physician/Contact_____

_____

Pharmacy/Contact_____

_____

Allergies to medications (Please also include reaction):

_____

Please mark if you have/had any of the following:

Anemia _____ Gout _____

Arthritis _____ Neuropathy___

Back Pain ___ Thyroid Disease ____

Bleeding Disorders ____ Circulatory Disorders ____

Swelling ____ Diabetes_____

Rash ____ Foot/Leg Cramps ____

Tired Feet ___ Ulcers_____

High Blood Pressure _____ High Cholesterol___

Heart Disease _____ Liver Disease _____

Cancer _____ Stroke_____

Other _____

Surgeries_____

Height _____**ft** **in** Weight ____**lbs**

Shoe Size _____

Current medications including dosage, and frequency, also any vitamins/supplements.

_____

_____

_____

_____

Please mark all that apply:

Alcohol use?_____ How often?_____

Tobacco use?_____ How much?_____

Caffeine use?_____How much?_____

Exercise?_____ Activity?_____

Other_____

Have you had your Covid Vaccine? Yes No

Have you had your Covid Booster? Yes No

Have you had a flu vaccine this season? Yes No

If Yes, please list date: Month _____Year_____

Have you had a pneumonia vaccine this year? Yes No

If YES, please list date: Month_____ Year_____

HgA1c Percentage (patients 18 years or older who have diabetes): _____%

Date of last HgA1c: _____

Doctor who obtains this bloodwork/lab: _____

Family History

Please check if any apply to any of your immediate relatives

Arthritis_____ Thyroid Disease ____

Cancer_____ Kidney Disease_____

Diabetes_____ Liver Disease_____

Gout_____Rheumatoid Disease_____

Heart Disease_____Stroke_____

Other_____

I certify that the above information is true and accurate to the best of my knowledge.
Printed Name: _____ *Signature:* _____ *Date:* _____

Disclosure of Healthcare Information/ Advanced Directives

Name: _____ Date of birth: _____

Patient confidentiality is of the utmost importance. We prefer to speak directly to the patient. However, occasionally we have been asked to release information to another individual.

Can we leave information on your answering machine/voice mail? _____Yes ____No

Do you give permission for the Lake Zurich Foot Clinic to discuss your medical condition and information about your care with any family members or close friends? ___ Yes _____ No

If yes, please provide names and contact information below:

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____
3. _____ Relationship: _____ Phone: _____

Do you have a living will or advance directive? _____ Yes _____No

If yes, does this document specify any limitations for care in the event of an emergency (such as no blood products or transfusions, no intubation/ventilator, no CPR or resuscitation in the event of cardiac arrest, etc.)? If so, please document below and discuss these with your doctor.

_____

If yes, does the document specify someone to have medical power of attorney (POA) for your affairs (i.e. someone designated to make decisions about your care and consent to procedures if you are unable to)?

_____ Yes _____ No Named POA: _____ Phone: _____

Printed Name: _____ Signature: _____

Date: _____

Financial Policy

1. Statements are mailed out at the end of each month. Payments are due 28 days after the statement date, unless payment arrangements have been made. If no payment is received by the next statement date, a ***late fee*** of **$20** will be added to the balance due.

2. We require that patients with self-pay balances pay their account to zero (0) prior to receiving further services from our practice.

3. Balances that have not received any payments for 3 months may be referred to a collection agency. Additionally, a 35% collection fee may be assessed.

4. Patient medical records are the property of the Lake Zurich Foot Clinic. Any patient requesting a copy of their medical record will be a charged a fee that follows guidelines set by Illinois state mandate.

5. All patients are responsible to know and monitor their insurance benefits. Important things to pay attention to are copays, deductibles, referrals, non-covered services, and whether the doctor is in-network with your plan. Please inform us if your insurance has changed to prevent payment delays.

6. We ask that if you should need to cancel your appointment, please give us at least 24-hour notice. Failure to show up for a scheduled appointment will result in a $50.00 no-show fee. Patients who repeatedly fail to keep appointments may be terminated from the practice.

I understand the above stated financial policy of the Lake Zurich Foot Clinic. I have been given an opportunity to have all my questions answered regarding these policies. I agree to accept financial responsibility for any charges incurred.

Printed Name: _____ Signature: _____

Date: _____