Welcome to Our Practice

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home (_____) _____ Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Ext _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. E.V. ISADORE DPM all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

ST CHARLES PODIATRY ASSOC, LLC
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

Have you ever been to a Podiatrist before?

☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Athletic activities in which you participate (please list and indicate frequency) _____

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or Numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape	☐ Local Anesthetics
☐ Anticoagulant Therapy	☐ Novocaine
☐ Aspirin	☐ Penicillin
☐ Codeine	☐ Seafoods
☐ Demerol	☐ Sulfa
☐ Iodine	

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

ST. CHARLES PODIATRY ASSOCIATES
COMMUNICATION CONSENT

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996, a federal law. Administrative Simplification section of this ACT is of concern to our practice and requires us to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare Transactions and Code Sets for transmitting electronic data
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protection of electronic health information

All of these rules have been developed by the Department of Health and Human Services and will become final in a staged manner.

It will be the policy of St. Charles Podiatry Associates to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, email, cellular phone, pager and/or fax. Whenever returning phone calls and an answering machine picks up, we will not leave a message if the name or number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer your telephone.

**** If you would like your medical information released to someone other than yourself, please complete the following:**

**** I authorize St. Charles Podiatry Associates to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.**

Home Telephone	Yes	No	
Work Telephone	Yes	No	Ph#_____
Voice Mail	Yes	No	
Cellular phone	Yes	No	Ph#_____
E-Mail	_____		

Please list authorizations: (include phone numbers with area code)

Name/Relationship: _____ Ph#_____

Name/Relationship: _____ Ph#_____

Name/Relationship: _____ Ph#_____

PATIENT SIGNATURE: _____ Date:_____

GUARDIAN SIGNATURE:_____ Date:_____

(If patient is a minor)

ST. CHARLES PODIATRY ASSOCIATES, LLC
ERNEST V. ISADORE DPM, PC
DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY
RANDALLWOOD
2210 DEAN STREET, SUITE C
ST. CHARLES, IL 60175
(630) 377-5001

AUTHORIZATION TO RELEASE BILLING AND MEDICAL INFORMATION

I Hereby authorize Dr. E.V. Isadore to release to employer groups, insurance companies, health maintenance organizations, government agencies or other third-party payers including collection agency and their agent's information concerning medical care, advice treatment or supplies and any other information that may be necessary for the purpose of determining eligibility for those benefits available for payment for healthcare services provided to me or my minor children. This authorization may be revoked in writing at any time except to the extent that actions have been taken in reliance thereon prior to revocation.

PAYMENT GUARANTY AND ASSIGNMENT OF BENEFITS

I hereby assign to Dr. E.V. Isadore all my right to payment under and Insurance policy, employee benefit plan or other medical expense reimbursement agreement for medical services rendered to me or my minor children by E.V. Isadore by a third-party pursuant to this agreement.

AUTHORIZATION FOR RELEASE OF INFORMATION

I Hereby grant permission to E.V. Isadore to request and receive confidential medical information about me from my primary care physician and other specialty care physicians for purposes of coordination of care.

NON-COVERED SERVICES

I assume all monetary responsibility for services not covered by my insurance. Including Charges that are covered but applied to my calendar year deductible.

FINANCIAL AGREEMENT

I Agree to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to an attorney for litigation all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the court. I consent to be contacted via phone, cellular phone or by email by St Charles Podiatry Associates, LLC or by any other agency contracted by them.

AUTHORIZATION FOR TREATMENT

I hereby request and authorize Dr. Ernest V. Isadore to administer medical counseling and/or treatment and to perform such general procedures as they may deem necessary in the diagnosis and treatment of my foot condition. I further certify that to the best of my knowledge the information I have provided in the personal health history is true and accurate.

SIGNATURE_____**DATE**_____
___

PRINT NAME_____ **REVISED 04/2023**

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative if applicable (please print)

_____

Signature

A copy of the *Notice of Privacy Practices* is available in the office at the check-in counter.

It is also posted throughout the office in several locations.