

CENTER FOR PODIATRIC MEDICINE

4958 W. Irving Park Rd, Suite 200
Chicago, IL 65041

PATIENT INFORMATION

Thank you very much for selecting our team of professionals. We will strive to provide you with the best care. To help us to meet your healthcare needs, please complete this form. If you have any questions or need assistance, please ask us—we will be happy to help you!

Date _____

Last Name _____ First Name _____ Date of Birth _____

Soc. Sec. Number _____ - _____ - _____ Home Phone _____ Mobile Phone _____

Address _____ City _____ Zip _____

Email Address _____

Employer _____ Work Phone _____

Primary Physician _____ Phone _____ Fax _____

Address _____ City _____ Zip _____

Person to contact in case of emergency _____ Phone _____

INSURANCE INFORMATION

Are you insured? Yes No

Insurance Company _____ Plan No. _____ Group No. _____

Insurance Co. Address _____ City _____ Zip _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

MEDICARE

Medicare # _____ Program _____

Please continue on next page -->

CONFIDENTIAL HEALTH INFORMATION

Chief complaint _____

History of present illness _____

Medical History: please check and provide comments below for any "yes"

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (High blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Myocardial Infarct (Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problem
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	COPD (Lung Disease)
<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV (+)	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots/DVT
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy/Lactating
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	Other _____	

If you answered "yes", please explain _____

Previous hospitalizations/surgeries/major illnesses _____

Allergies: _____

Medications: _____

Family History (Major Illnesses of your parents, Brothers/Sisters, Children) _____

Please list medical Doctors you have recently seen (name, phone #) _____

ASSIGNMENT, AUTHORIZATION AND POLICY STATEMENT

I have answered all questions to the best of my knowledge and hereby give my permission to administer treatment for my medical problems. I hereby assign the benefits that I am eligible to receive for the care rendered in the office to the office. I authorize the office to release any information to any insurance company, adjustor, or attorney that will assist in the payment of a claim. I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance. A photocopy of this form shall be considered as valid as the original.

Signature _____

Date _____