

# Advanced Foot and Ankle Centers of Illinois



## Patient Information (Please Print)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ E-mail \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

## Please provide all insurance cards

**(Patient is responsible for verifying insurance coverage for all services)**

Primary Insurance Company \_\_\_\_\_ Insured's name \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Insured's name \_\_\_\_\_ DOB \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Former Podiatrist \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Medications you are taking \_\_\_\_\_

Allergies to Medications \_\_\_\_\_ Other Allergies \_\_\_\_\_

Have you had any surgeries or serious illnesses? \_\_\_\_\_

**Please check if you have or ever had any of the following:** \_\_\_ Diabetes \_\_\_ Stroke \_\_\_ Thyroid disease  
\_\_\_ HIV \_\_\_ Cancer \_\_\_ Asthma \_\_\_ Epilepsy \_\_\_ Varicose Veins \_\_\_ High Blood Pressure \_\_\_ Bursitis  
\_\_\_ Anemia \_\_\_ Heart Disease \_\_\_ Stomach Ulcers \_\_\_ Arthritis \_\_\_ Liver Problems \_\_\_ Hepatitis  
\_\_\_ Migraine Headaches \_\_\_ Leg Cramps \_\_\_ Glaucoma \_\_\_ Kidney Problems

**Patient Social History**

Use of Alcohol \_\_\_\_\_ Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderate \_\_\_\_\_ Daily  
Use of Tobacco \_\_\_\_\_ Never \_\_\_\_\_ Previously, but quit \_\_\_\_\_ Current packs per day  
Use of Drugs \_\_\_\_\_ Never \_\_\_\_\_ Type / Frequency \_\_\_\_\_

**History of Present Foot / Ankle Condition**

**Chief Complaint Today** \_\_\_\_\_

**Location** (Where is the Pain?) \_\_\_\_\_

**Severity** (How severe is pain? On scale 1-10 with 10 being worst) \_\_\_\_\_

**Duration** (How Long / When did the pain start) \_\_\_\_\_

**Timing** (Does this pain occur at a specific time of day?) \_\_\_\_\_

**Traumatic injury or incident?** \_\_\_\_\_

**Family Medical History**

|          | Age   | Diseases | if deceased, cause of death |
|----------|-------|----------|-----------------------------|
| Father   | _____ | _____    | _____                       |
| Mother   | _____ | _____    | _____                       |
| Siblings | _____ | _____    | _____                       |

\*I hereby give my permission to the physician (s) of Advanced Foot and Ankle Centers of Illinois to administer any non-surgical treatment that may be necessary to treat my foot / ankle condition

\*I understand that I am financially responsible for all charges (whether or not covered by my insurance)

\*I understand that if I receive a check from my insurance company for services provided by Advanced Foot and Ankle Centers of Illinois, I am responsible for paying the Center immediately. **Co-payment must be paid at the time of service**

I authorize the release of any medical information necessary to process my insurance claim

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I authorize payment of medical benefits to Advanced Foot and Ankle Centers of Illinois

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_