**TALCOTT FOOT & ANKLE SPECIALISTS, P.C.**
**7447 W. Talcott Ave., Suite 214, Chicago, IL 60631, Tel: (773) 594-9700; Fax: (773) 594-0095**

# REGISTRATION

**Date**_____ **Home Phone**_____**Work Phone**_____ **Cell Phone**_____
**Patient**_____
Last Name First Name Initial
**Street Address**_____ **City** _____ **State** _____ **Zip** _____
**Sex** ☐ M ☐ F **Age**_____ **Birth date**_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
**Ethnicity** ☐ Hispanic ☐ Non-Hispanic **Race** ☐ African American ☐ Asian American ☐ Caucasian ☐ Native American ☐ Other
**Social Security #**_____ **E-mail** _____
**Insured Name**_____How and where did you learn about this clinic? _____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

| | |
|---|---|
| **EMPLOYER** | Company Name_____ Occupation_____<br>Address_____ Phone_____ ☐ Full-time ☐ Part-time<br>City State Zip |
| **SPOUSE (PARENT)** | Name_____<br>Last Name First Name Initial<br>Birthdate_____ Social Security #_____<br>Employer Name_____ Occupation_____<br>Address_____Phone_____<br>City State Zip |
| **PATIENT INSURANCE INFORMATION** | Please list any and all insurance and/or employee health care plan coverage you or your spouse may have<br>Insurance Company or Health Care Plan Name_____<br>Policy/Group #:_____ Effective Date:_____<br>Name of Insured:_____ID #:_____ |
| **SPOUSE COINSURANCE INFORMATION** | Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have<br>Insurance Company or Health Care Plan Name_____<br>Policy/Group #:_____ Effective Date:_____<br>Name of Insured:_____ID #:_____ |
| **MEDICAL AND LEGAL INFORMATION** | Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ **Yes** ☐ **No** Your Initials:_____<br>If you answered yes, please fill out accident specific form, available at the front desk.<br>Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____<br>Person to contact in emergency (Name and Phone #)_____<br>Attorney_____ Telephone:_____<br>Address_____ |
| **PATIENT AGREEMENT** | **LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**<br>In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Talcott Foot & Ankle Specialists, P.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.<br>I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.<br>This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.<br><br>_____ _____<br>Signature of Insured / Guardian Date |

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# Medical Information

This information is important for our records and your health.

Describe your foot problem _____
_____
_____
_____

How long has it been bothering you? _____ Days _____ Weeks _____ Years _____

Any past problems of your feet and ankles? _____
_____
_____
_____

Any past surgical procedures on your feet and ankles? _____
_____
_____

Shoe size _____ Current weight _____ Height _____

Are you allergic or sensitive to:

Antibiotics (Penicillin, Sulfa drugs, etc?) _____
Any medicines _____
Reaction _____ Severity □ Very Mild □ Mild □ Moderate □ Severe
Tape? _____ Betadine (Iodine)? _____ Other _____
Have you had any problems taking aspirin or ibuprofen (Advil, Motrin)?
Yes _____ No _____
Any problems with local anesthetics (Novocaine, Lidocaine)? Yes ____ No ____

## GENERAL HEALTH INFORMATION

Do you have Diabetes? Yes ____ No ____ If, yes, do you take insulin? Yes ___ No ____
Number of years _____
Have you had any serious illnesses? _____
Have you had any major surgeries? _____
Are you under a physician's care? Yes ____ No ____ If yes, for what condition? _____
_____
Family Physician _____ Date you last saw this Doctor _____
May we contact your physician about your health? Yes _____ No _____
Name of your Pharmacy or Drug Store _____ Phone # _____
What medications do you take regularly? (Please be sure to list dosage and any over the counter meds)_____
_____
_____
_____

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Check ( ) any of the following you have, or have had a problem with:

| | | | |
|---|---|---|---|
| ( ) Heart | ( ) Asthma | ( ) Gout | ( ) High Blood Pressure |
| ( ) Circulation | ( ) Stomach Ulcers | ( ) Tuberculosis | ( ) Unexplainable Weight Loss |
| ( ) Arthritis | ( ) Hormones | ( ) Rheumatic Fever | ( ) Frequent Infections |
| ( ) Kidneys | ( ) Anemia | ( ) Liver | ( ) Neurological Disorder |
| ( ) Lungs | ( ) Bladder | ( ) Healing | ( ) Intestines |
| ( ) Cancer | ( ) Skin | | |

Do you have any artificial joints?

Hip Yes _____ No _____
Knee Yes _____ No _____
Other _____

## FAMILY HISTORY

Mother Living _____ Deceased _____ Cause of Death _____
Father Living _____ Deceased _____ Cause of Death _____
Brother Living _____ Deceased _____ Cause of Death _____
Sister Living _____ Deceased _____ Cause of Death _____

Is there a family (blood relative) history of:

( ) Heart Disease
( ) Bleeding Disorder
( ) Neurological Disorder
( ) Stroke
( ) Bunions
( ) Hammertoes
( ) Flatfeet
( ) Circulation problems in legs or feet

Do you smoke? Yes _____ # of packs per day _____ No _____
Previously smoked? Yes ____ No _____

Do you drink alcohol or beer? Yes _____ No _____
( ) Light usage 1-2 per week ( ) Moderate 1-2 per day ( ) Heavy, more than 2 daily

Employment: ( ) Sits at job ( ) Stands at job ( ) Stands & walks at job ( ) Retired

Signature _____ Date _____

# Talcott Foot & Ankle Specialists, P.C.

# ACKNOWLEDGMENT OF RECEIPT

**OF**

# NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided 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)

_____

**Signature**

If you would like a copy of the *Notice of Privacy Practices*, please inform the receptionist.

# YOUR PAYMENT OPTIONS

*We are pleased to welcome you to our office. New patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring doctors and patients. As our patient, please feel free, at any time, to express any concerns or to ask any questions that you may have for the doctor or our staff. In order to assist you in making payment for your podiatric treatment, the following options are listed. Please read them carefully and feel free to discuss them with us.*

**IF YOU DO NOT HAVE INSURANCE**, payment is due in full at the time treatment is provided.

**PAYMENT**- You may make any payment using cash, check, VISA, MasterCard, or Discover. Please note there is a three dollar processing fee for partial payments and use of credit cards.

**IF YOU HAVE COMMERCIAL INSURANCE**, we will submit your form to your insurance carrier for you. You are responsible, at the time of your appointment, for any deductible or co-payment not covered by insurance. If the exact amount of insurance coverage can not be determined at the time of your appointment, we request that you pay your deductible and 20% of any remaining cost of your treatment. Once our office has received payment from the insurance company, you will be billed, with 30 day terms, for any amount still owed, or you may fill out a voucher and have the amount applied to your credit card amount. If there is a payment credit, a check will be issued to you within 30 days.

**MEDICARE PATIENTS**: This office accepts Medicare assignment. Medicare patients are fully responsible, however, for the initial yearly deductible and the 20% co-payment. Federal law requires that physicians collect this amount. This payment is to be made at the time services are rendered. If you have a co-insurance to cover 20%, we will submit the insurance form for payment and you will only be responsible for the deductible and other non-covered services.

**HMO PATIENTS**: It is your responsibility to provide all necessary referral forms at the time of your visit. You will be responsible for all non-approved services if you did not have a referral for the services rendered. Co-payments must be made at the time of your visit.

**INSURANCE PATIENTS- PLEASE READ CAREFULLY**: The percentage of coverage by your insurance company may be based on your insurance company's fee schedule and may be less than actual charges, resulting in lower coverage for you. We have no control over this situation. Lower payment is direct result of the plan selected by your employer. For plans where we have a contractual agreement with, you will not be held liable for the difference between our fee and the "Approved Fee".

**PLEASE BE ADVISED THAT WE CAN NOT WAIVE CO-PAYMENT OR DEDUCTIBLE**. We are required by law to collect co-payments and deductibles.

**EXTENDED CARE CASES**: Special arrangements may be made for extended care cases. Please see our Office Manager.

I have read and understand the above conditions.

Signature: _____ Date: _____