Northwest Surgical Specialists, P.C.

Tel: (847) 885-9525 Fax: (847) 885-9527
3100 W. Higgins Road, Suite 150, Hoffman Estates, IL 60169
NorthwestSurgicalSpecialists.com

PODIATRY REGISTRATION

Section 1: Patient Identification & Contact Information

Patient Account #

First Name MI: Last Name:

Your type of Job Activity/Occupation:

☐ I prefer to be addressed as:
MR. MRS. MISS MS. DR.
☐ I prefer to be addressed by:
○ First Name
○ Nick Name:

Last digits of Social Sec. #:	Sex M / F	Age	Birthday / /	Shoe Size:	Weight:	Height:

Phone Numbers for Contact You:
Day: (_____) _____-_____
Evening: (_____) _____-_____
Cell/Pager: (_____) _____-_____

In Case of Emergency, Please Call:
_____
Day: (_____) _____-_____
Evening: (_____) _____-_____

Please Provide Your Preferred Pharmacy:
_____
Street / City: _____
Day: (_____) _____-_____

Section 2: Comprehensive Patient Medical History

■ **Have you had/been treated for:**

☐ Warts	☐ Athlete's Foot	☐ Ingrown Nails
☐ Corns/Calluses	☐ Fungal Nails	☐ Leg or Foot Ulcers
☐ Neuroma	☐ Broken Foot Bone(s)	☐ Broken Ankle
☐ Ankle Sprain	☐ Bunions	☐ Hammer/Mallet Toes
☐ Flat Feet	☐ Cramps in legs/feet	☐ Childhood Foot Problems
☐ Arch Pain	☐ High Arch Feet	☐ Lower Back Pain
☐ Knee Pain	☐ Heel Pain	☐ In-toeing
☐ Toe Walking	☐ Rash	☐ Gait (Walking) Problems

☐ **NONE of these**

■ **Did you previously or do you now wear:**
Shoe inserts? [Y] [N] Still using them? [Y] [N] Do or did they help? [Y] [N]
Orthotics? [Y] [N] Still using them? [Y] [N] Do or did they help? [Y] [N]

■ **The orthotics were obtained from:** ☐ Another Podiatrist ☐ An Orthopedist
☐ A Physical Therapist ☐ A Chiropractor ☐ Other: _____

■ **Are your first steps out of bed painful?** [Y] [N] ... then subsides? [Y] [N]
■ **Do you get leg cramps...during the day?** [Y] [N] .... at Night? [Y] [N]
■ **Percent of waking hours spend on your feet?** [20%] [40%] [60%] [80%] [100%]
■ **List the sports/type of dance you are active in:**
_____

■ **Does foot pain limit your desired activities?**	☐ **Yes**	☐ **No**
■ **Do you have any difficulty in walking?**	☐ **Yes**	☐ **No**
■ **Any pain in calves or buttocks when walking?**	☐ **Yes**	☐ **No**
■ **Is the pain relieved by stopping & standing still?**	☐ **Yes**	☐ **No**
■ **Do you have or have ever been treated for:**		

☐ Stoke	☐ Heart Attack	☐ High Blood Pressure
☐ Phlebitis	☐ Vascular Disease	☐ A Heart Condition
☐ Anemia	☐ Poor Circulation	☐ Eyes: Glaucoma/Manicular Deg.
☐ Diabetes	☐ Kidney Disease	☐ Keloid/Thick Scar
☐Gout	☐ Osteoporosis	☐ Alzheimer's
☐ Sciatica	☐ Lyme's Disease	☐ Rheumatic Fever
☐ Arthritis	☐ Headaches	☐ Hearing/Ear Disorder
☐ Epilepsy	☐ Nerve Disorder	☐ Psychiatric Disorder
☐ Asthma	☐ Lung Disease	☐ Tuberculosis
☐ Hepatitis	☐ Liver Disease	☐ Thyroid Problem
☐ Dark Urine	☐ Chronic Light Stool	☐ Unexplained Weight Loss
☐ Cancer	☐ Stomach Ulcer	☐ **NONE of these**

☐ Other(s): _____

■ **Do you have vascular grafts?** (If yes, explain below)
■ **Do you have joint implants?** (If yes, explain below)
■ **Do you have replacement heart valves?**
■ **Are you now under active chemotherapy?**
■ **Have you had any other serious illness?** (If yes, explain below)
■ **Have you had any surgery?** (If yes, explain below)
■ **Have you ever been hospitalized or been under medical care for over 24 hrs?** (If yes, explain below)

I Had Surgery for:	on date of:	w/complications of:

■ **List relationship to you of family members who have had:**
Diabetes _____ Foot Problems _____
Arthritis _____ Heart Attack _____
Stroke _____ High Blood Pressure _____
Cancer _____ Birth Defects _____

■ **# of childbirths ____ Are you currently pregnant?**	☐ **Yes**	☐ **No**
■ **Are you slow to heal after cuts?**	☐ **Yes**	☐ **No**
■ **Any abnormal bruising, bleeding, or scarring?**	☐ **Yes**	☐ **No**
■ **Do you smoke now?**	☐ **Yes Packs/day____ Years ___**	☐ **No**
■ **Did you ever smoke?**	☐ **Yes Packs/day____ Years ___**	☐ **No**

If you quit, when did you do so?_____

■ **Alcoholic Beverages?** (Circle One) None Rarely Moderately Daily Quit
■ **Recreational Drugs?** (Circle One) None Rarely Moderately Daily Quit
■ **Please mark if you take vitamins or supplements that contain**
☐ Garlic ☐ Gingko Biloba ☐ Echinacea ☐ Ginseng ☐ St. John's Wort
■ **Are you currently taking any medications?** (List Below) ☐ **Yes** ☐ **No**
■ **Are you taking Insulin?** If yes, list below ☐ **Yes** ☐ **No**

■ **List: Medications**	**Does?**	**How Often?**	**For Treatment of?**
_____	_____	[A], ___ x/ [D] [W],	_____
_____	_____	[A], ___ x/ [D] [W],	_____
_____	_____	[A], ___ x/ [D] [W],	_____
_____	_____	[A], ___ x/ [D] [W],	_____
_____	_____	[A], ___ x/ [D] [W],	_____

■ **Are you taking your medications as prescribed?** ☐ **Yes** ☐ **No**
■ **Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral, or tropical administration of:**

(Check the answer box that applies)	**If yes, what happens?**	
Latex, Adhesive tape (circle).....	☐ **No**	☐ **Yes** _____
Penicillin.....	☐ **No**	☐ **Yes** _____
Other Antibiotics (List below).....	☐ **No**	☐ **Yes** _____
Empirin, Tylenol (if yes, circle.....	☐ **No**	☐ **Yes** _____
Asprin, Advil, Aleve, or Mortin (if yes, circle)..	☐ **No**	☐ **Yes** _____
Celebrex.....	☐ **No**	☐ **Yes** _____
Other pain remedies (List below).....	☐ **No**	☐ **Yes** _____
Morphine.....	☐ **No**	☐ **Yes** _____
Codeine.....	☐ **No**	☐ **Yes** _____
Demerol.....	☐ **No**	☐ **Yes** _____
Other narcotics (List below).....	☐ **No**	☐ **Yes** _____
Novocaine.....	☐ **No**	☐ **Yes** _____
Other anesthetics (List below).....	☐ **No**	☐ **Yes** _____
Sulfa drugs.....	☐ **No**	☐ **Yes** _____
Shrimp, Iodine, or Merthiolate.....	☐ **No**	☐ **Yes** _____
Any other drugs or medications.....	☐ **No**	☐ **Yes** _____

Others: _____

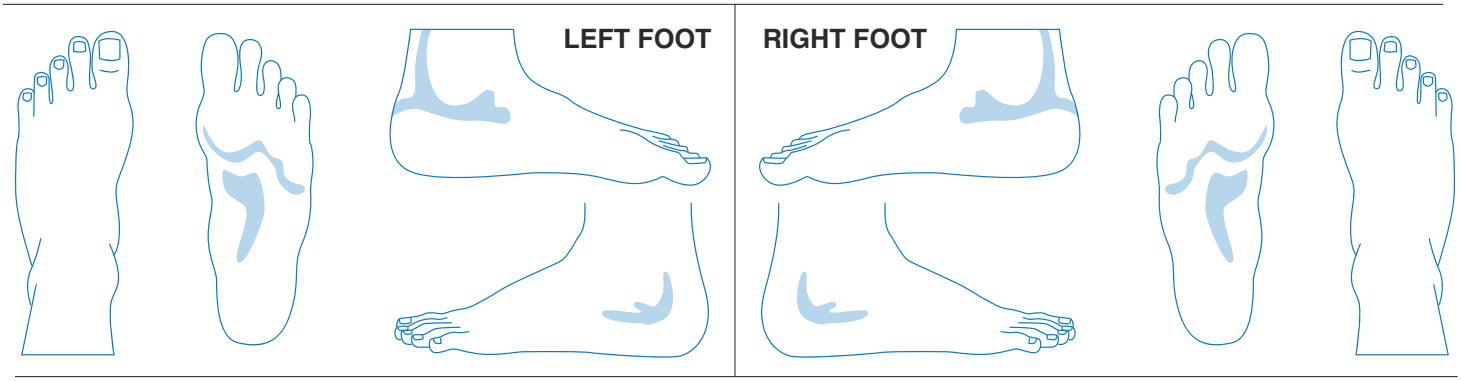
■ **Anything else that you want to tell the doctor?** ☐ **Yes** ☐ **No**
_____
_____

PLEASE CONTINUE TO PROVIDE ADDITIONAL DETAILS.

Patient Account # _____

Section 3: Patient's Current Chief Complaints

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the area where you have each problem using numbers 1 & 2 to identify them.



1 **Please mark the location of your first problem or pain the diagram above with a number 1.** Describe your problem below and its cause if you know. Please describer associated pain to the right. ➔

■ My first problem is... ☐ On Left Foot ☐ On Right Foot ☐ On Both Feet

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it....

_____

_____

_____

_____

_____ is problem work related? [Y] [N]

Date of injury: ____/____/_____ Date of report to employer: ____/____/_____

■ **PAIN: Please indicate the severity of your pain or discomfort:**

[0] None.... [1] Light.... [2] Moderate... [3] Strong... [4] Severe

■ **My Pain/Discomfort is:**

☐ Shooting Pain
☐ Throbbing Pain
☐ Sharp Pain
☐ Burning Pain
☐ Itching
☐ Aching Pain
☐ Tenderness
☐ Dull Pain
☐ Tingling
☐ Numbness

■ **How long ago did the problem (pain) start?:**

_____ ☐ days, ☐ weeks, ☐ months, ☐ years ago

■ **The pain from my problem occurs:**

☐ while walking and/or ☐ while not walking

☐ and/or: _____

_____

Any previous medical treatment(s) or home remedies:

_____

_____

_____

2 **Please mark the location of your first problem or pain the diagram above with a number 2.** Describe your problem below and its cause if you know. Please describer associated pain to the right. ➔

■ My first problem is... ☐ On Left Foot ☐ On Right Foot ☐ On Both Feet

It causes me difficulty: ☐ walking, ☐ wearing shoes, and/or it....

_____

_____

_____

_____

_____ is problem work related? [Y] [N]

Date of injury: ____/____/_____ Date of report to employer: ____/____/_____

■ **PAIN: Please indicate the severity of your pain or discomfort:**

[0] None.... [1] Light.... [2] Moderate... [3] Strong... [4] Severe

■ **My Pain/Discomfort is:**

☐ Shooting Pain
☐ Throbbing Pain
☐ Sharp Pain
☐ Burning Pain
☐ Itching
☐ Aching Pain
☐ Tenderness
☐ Dull Pain
☐ Tingling
☐ Numbness

■ **How long ago did the problem (pain) start?:**

_____ ☐ days, ☐ weeks, ☐ months, ☐ years ago

■ **The pain from my problem occurs:**

☐ while walking and/or ☐ while not walking

☐ and/or: _____

_____

Any previous medical treatment(s) or home remedies:

_____

_____

_____

Section 4: Patient's Doctors - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE.

■ My:	Physician's Name:	Phone Number	City	Date Last Seen	Referred me: I was sent or came in especially for:
Family/ Primary	_____	_____	_____	____/____/_____	[Y] [N] [2nd Opinion] [Surgcl Eval] [Consult]
Specialist	_____	_____	_____	____/____/_____	[Y] [N] [2nd Opinion] [Surgcl Eval] [Consult]
Other Podiatrist	_____	_____	_____	____/____/_____	[Y] [N] [2nd Opinion] [Surgcl Eval] [Consult]

Section 5: For Doctor's Use - OBSERVATIONS & COMMENTS

☐ Patient was ☐ assisted in completion of this record by or was ☐ Unable to complete without help of: _____

☐ Translation was done by: _____ in ☐ Spanish, ☐ Other, List: _____

☐ Additional Information obtained from ☐ Family/Care Giver(s) and/ or ☐ Physician(s) _____

☐ Lab Reports and/or ☐ Previous Medical Records were reviewed. ☐ X-Rays brought by patient from_____ were reviewed.

Elaborations: _____

_____

_____

_____

I have reviewed the information provided above _____. ☐ My annotations to patient's entries are marked in: _____

Doctor's Signature x_____ Date ____/____/_____ ☐ See Additional Documentation *(INK COLOR)*

Confidential Office Medical Record ☐ *QA Review by* _____ *on* ____/____/_____ ☐ *Only Changes to the Previous History Information Are Noted*

PLEASE CONTINUE ON THE OTHER PAGES.

Patient Account # _____

DETAILED INSURANCE INFORMATION

PATIENT INFORMATION

■ **Name**_____ **Birthdate:** _____/_____/_____

(Last Name, First Name, Initial)

■ **Social Security #**_____ ■ **Driver's License #**_____

■ **Insured Name**_____ ■ **Relationship to Insured**

(Last Name, First Name, Initial) □ **Self** □ **Spouse** □ **Child** □ **Other**_____

■ **Condition/ Illness Related To:** □ **Illness** □ **Auto** □ **Employment** □ **Other:** _____

■ **Company Name**_____ ■ **Occupation**_____

■ **How and where did you learn about this facility?** □ **Web** □ **Newspaper** □ **Article** □ **Family/Friend**

□ **Other:** _____

EMPLOYER

Address_____ **City** _____ **State** _____ **Zip**_____

Years Employed:_____ **Phone**_____ □ **Full-time** □ **Part-time**

PATIENT INSURANCE INFORMATION

■ **Name**_____ **Birthdate**_____

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name:_____

■ Policy/Group #:_____ Effective Date:_____

■ 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:**_____

If you answered yes, please fill out accident specific form, available at the front desk.

Pregnant: □ Yes □ No **Pacemaker:** □ Yes □ No

Allergies_____

Family Physician _____

Address_____ **City** _____ **State** _____ **Zip**_____

Telephone:_____ Date of Last Visit _____

Person to contact in emergency Name: _____ Phone: _____

SPOUSE (PARENT)

■ **Name**_____ **Birthdate:** _____/_____/_____

(Last Name, First Name, Initial)

■ **Social Security #**_____ ■ **Employer Name**_____

■ **Occupation:** _____ ■ **Phone:** _____

■ **Address:**_____

SPOUSE COINSURANCE INFORMATION

Name_____ **Birthdate**_____

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name: _____

Policy/Group #:_____ **Effective Date:**_____

Name of Insured:_____**ID #:**_____

PLEASE CONTINUE ON THE OTHER PAGES. **Patient Account #** _____

NOTICE OF PRIVACY PRACTICES

This notice Describes How Medical Information About You May Be Used and Disclosed, and How You Can Get Access to this Information. **PLEASE REVIEW CAREFULLY.**

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your; health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations: Your health information may be used, as necessary, to support the day-to-day activities and management of Northwest Surgical Specialists. For Example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting. Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of you decision.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Additional Uses of Information

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to gain access to your records by contacting our receptionist or privacy officer.

Northwest Surgical Specialists' Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Northwest Surgical Specialists
3100 W. Higgins Rd., Suite 150
Hoffman Estates, IL 60195

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filling a complaint.

How to Contact The Joint Commission to Report Concerns About Safety Quality of Care:

The Joint Commission
800-994-6610
www.jointcommission.org

PLEASE CONTINUE ON THE OTHER PAGES.

Patient Account # _____

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.

SIGN HERE

_____ _____

Patient's Name (Please Print) Date

_____ _____

Authorized Representative (If Applicable) Signature

PATIENT AGREEMENT

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

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 Northwest Surgical Specialists all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and facility. 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 facility any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and facility 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.

I hereby convey to the above named doctor and facility 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 facility 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 facility in any attempts by such doctor and facility 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 facility against such insurers and/or employee health care plan in my name but at such doctor and facility's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

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.

SIGN HERE

_____ _____

Signature of Insured / Guardian Date

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of your protected health information will be used by Northwest Surgical Specialists, or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the organization.

Notice of Privacy Practices

I have had an opportunity to review the Notice of Privacy Practices on how my protected health information may be used or disclosed. I understand that I may revoke this consent at any time, but it must be in writing. Any use or disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected.

Consent to Disclose Patient Information

I give my permission to Northwest Surgical Specialists, P.C. to use and disclose my health information to the following:

Name	Relationship	Phone Number

Signature

I have reviewed this consent form and give my permission to Northwest Surgical Specialists P.C. to use and disclose my health information in accordance with it.

SIGN HERE

Name of Patient (Print):_____ Date:_____

Signature of Patient:_____

Signature of Patient Representative:_____

Relationship of Patient Representative to Patient:_____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (Date):_____ Time:_____ (circle) a.m. p.m.

By (Name & Title):_____

This is an indefinite consent form unless otherwise specified

PLEASE CONTINUE ON THE OTHER PAGES.

Patient Account # _____