Foot & Ankle Care **Michael A. DeVito DPM** **Chicago Ridge, IL**

PATIENT NAME: _____DOB ____/____/_____ SEX: M / F

(PLEASE PRINT) LAST FIRST MI

ADDRESS: _____CITY/STATE/ZIP: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

E-MAIL ADDRESS: ----------

(WE DO NOT SHARE YOUR E-MAIL, YOU WILL RECEIVE APPOINTMENT REMINDERS)

PRIMARY CARE DOCTOR: ---------- PHONE: _____

PHARMACY: _____ CITY: _____ CROSS STREETS: _____

PRIMARY LANGUAGE: ENGLISH / SPANISH / POLISH / ARABIC /OTHER: _____

ETHNIC ORIGIN: AFRICAN-AMERICAN / ASIAN / HISPANIC / WHITE / OTHER: _____

PRIMARY INSURANCE: _____

ID# _____ GROUP# _____

SUBSCRIBER NAME: _____DOB: _____ EMPLOYER: _____

SECONDARY INSURANCE: _____ID#_____ GROUP# _____

SUBSCRIBER NAME: _____DOB:_____ EMPLOYER: _____

Authorization For Treatment & Release of Information

I authorize Michael A DeVito DPM and or his designated assistant to administer treatment to include minor operative procedures as may be necessary in the diagnosis or treatment of my foot condition. I authorize doctor and staff to view my prescription history. I understand that I am financially responsible for all charges or balances regardless of any applicable insurance payments. I understand that these balances are due within 90 days from the date of insurance payment and/or denial. If outside collection attempts are necessary, I will be responsible for all collection, legal or late fees. I authorize the doctor to release all medical information necessary to process and adjudicate claims. I authorize my insurance carrier to make benefit payment directly to Michael A. DeVito on my behalf. I authorize any plan administration or fiduciary and/or my attorney to release any and all plan documents, insurance policy and/or settlement information upon written request from this practice in order to process claims. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This practice participates in a health information exchange program where clinical information about our patients' care is shared electronically through a secure web portal between this practice and other physicians/providers also providing care to our patients. Basic information is shared for better patient care and the information is used for no other purposes. I have been directed to HIPAA notice of Privacy Practices and understand I may obtain a written copy of that notice upon request.

This assignment will remain in effect until revoked by me in writing. A photocopy or electronic scan of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____DATE:_____

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PAYMENT IS DUE AT TIME OF SERVICE

Please read this page carefully and sign the bottom of the page indicating your understanding and acceptance of our financial policies and procedures.

If you have health insurance, as a courtesy, we will submit your claim to insurance on your behalf. Not all of the situations below apply to all plans.

Co-Pays are due at the time of service for *each* office visit.

- This is per your insurance contract agreement.
- Your plan sets the Co-Pay amount, not our office.

UNMET DEDUCTIBLES

- **If You Have NOT Met You Plan Deductible At The Time Of Your Visit We Will Request Payment.**
- **This may be the entire amount owed or just a portion of what you are expected to owe.**
- **Charges will be submitted to your insurance company; payment will be applied to claim.**

You may still receive a bill from our office *if a balance remains* ***after*** *your payment*. Should insurance pay in full we will refund your payment**.**

- **Insurance verifications are quotes of benefits only and do NOT guarantee coverage of any kind and are based on the information the patient has provided to our office.**

- ***Insurance verification does NOT guarantee that a service will be paid for by your insurance plan*.** Patient is responsible for all charges regardless of insurance coverage.

****Podiatry is specialist medical care and podiatry benefits may differ from your regular doctor***
* Co-Pays, Deductibles & Co-insurance may be higher for specialty care per your plan

****Your insurance is a contract between you, employer (if applicable) and insurance company***
*Our office is not included in your agreement.

****Not all services are covered by all insurance policies.***
* Some companies select certain services to exclude. Our office has no control over coverage**.**

I have read and understood practice financial policy and agree that I am responsible for all charges regardless of any insurance coverage

PATIENT/PARENT/GUARDIAN SIGNATURE: _____**DATE**:_____

Are you a Diabetic? ☐ **Yes** ☐ **No** **If Yes, Do you take insulin?** ☐ **Yes** ☐ **No**

Are you currently pregnant? ☐ **Yes** ☐ **No** **Are you currently breastfeeding?** ☐ **Yes** ☐ **No**

Medications: please list all current medications you are taking below *(if you have a list please give to front desk)*

If you are *not* taking any medication please check NONE ☐

(Mark an "X" if any of the conditions below apply to you)

MAJOR ILLNESSES		**RESPIRATORY**		**EENT**	
DIABETES		ASTHMA		SINUS PROBLEMS	
HEART DISEASE		BRONCHITIS		TONSILLITIS	
HIGH BLOOD PRESSURE		EMPHYSEMA		THROAT INFECTIONS	
CHEST PAINS/ANGINA		SHORTNESS OF BREATH		GLAUCOMA	
HEART ATTACK		CHRONIC LUNG DISEASE		CATARACTS	
CANCER				EYE/VISION PROBLEMS	
MURMUR		**SKIN**		HEADACHES/ MIGRAINE	
IRREGULAR HEART BEAT		PSORIASIS		HEARING PROBLEMS	
STROKE		SKIN CANCER			
				PSYCHOLOGICAL	
GI		**VASCULAR/BLOOD DISORDER**		DRUG/ALCOHOL DEPENDENCY	
STOMACH ULCERS		POOR CIRCULATION		ANXIETY	
ACID REFLUX		LEG OR CALF PAIN		DEPRESSION	
HIATAL HERNIA		NIGHT CRAMPS		PSYCHIATRIC CONDITION	
STOMACH DISORDER		VEIN PROBLEMS		DEMENTIA	
BOWEL DISORDER		SWELLING TO LEGS			
HEMORRHOIDS		VARICOSE VEINS		**MISC. ILLNESSES**	
RECTAL FISSURES		LEG OR FOOT ULCER/WOUND		LYME DISEASE	
RECTAL BLEEDING		BLOOD CLOTS		EPILEPSY / SEIZURES	
		ANEMIA		THYROID DISEASE	
GENITO-URINARY		SICKLE CELL		HEPATITIS	
KIDNEY/BLADDER INFECTIONS		TRANSFUSIONS		FIBROMYALGIA	
KIDNEY STONES		NEUROPATHY		HIV / AIDS	
PROSTATE				HIGH CHOLESTEROL	
		ARTHRITIS		MULTIPLE SCLEROSIS	
		RHEUMATOID			
		DEGENERATIVE ARTHRITIS			
		GOUT			

Allergies: ☐ None Known ☐ Penicillin ☐ Sulfa ☐ Tape ☐ Latex ☐ Iodine ☐ Local Anesthetics ☐ Other: _____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE**:_____

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Surgical History (*list all prior surgeries*)

If you have no previous Surgeries please check NONE ☐

Date / Name of Procedure	Date/ Name of Procedure

Prior Hospitalizations: (*other than for surgery*)

If you have no Hospitalization please check NONE ☐

Date / Reason	Date / Reason

Family History (*please check all that apply*)

Father: ☐ Alive ☐ Deceased ____ High Blood pressure ____Diabetes ____ Cancer ___ Heart Disease

Mother: ☐ Alive ☐ Deceased ____ High blood pressure ____ Diabetes ____ Cancer___ Heart Disease

Patients Social History

Use of tobacco: ☐ Never ☐ Quit – How Long Ago? _____ ☐ Current Smoker

Use of alcohol: ☐ Never ☐ Rare ☐ Daily ☐ Occasional ☐ No Longer Use

FALL RISK

Have you fallen within the last year? ☐ No ☐ Yes If yes, any injury? _____

Employer: _____ **Occupation**:_____

Current Weight _____ **Height** _____ **Shoe Size** _____

What is the reason you are seeing the doctor today? (*check all that apply*)

☐ Right Foot ☐ LEFT FOOT

☐ INGROWN TOE NAIL ☐ HEEL PAIN ☐ WOUND ☐ HAMMERTOE ☐ BUNION

☐ DIABETIC FOOT CARE ☐ WART ☐ FUNGUS ☐ ATHLETES FOOT ☐ FLAT FEET

☐ SPRAIN/FRACTURE ☐ NAIL CARE ☐ TENDONITIS ☐ ANKLE PAIN ☐ LUMP/CYST

☐ GENERAL FOOT PAIN ☐ TINGLING/BURNING

☐ OTHER, PLEASE EXPLAIN:_____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____**DATE**:_____