Central DuPage Foot & Ankle Associates

Patient Registration Form

Patient Information

Name:

_____

(First) (M.I.) (Last)

Gender: ☐ Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

DOB: _____ SS # (**Required for All Patients**): _____

(IF CHILD, then responsible party)

Responsible Party (if a minor): _____

Email: _____ ☐NONE

Street Address: _____

City, State, Zip: _____

Primary Phone: _____ ☐Cell ☐Home☐Business **Can we leave a message:** ☐Yes ☐No

Other Phone: _____ ☐Cell ☐Home☐Business **Can we leave a message:** ☐Yes ☐No

Employer: _____Phone#: _____

Emergency Contact:

_____

(Name) (Phone Number)

How did you hear about our office?: _____

Preferred Language if other than English: _____

Pharmacy Name and Address: _____

Insurance Information

Primary Insurance:

Insurance Company and Address:_____

Insured Name:_____ DOB:_____ Relationship to Patient:_____

Member ID:_____ Group #:_____

Secondary Insurance:

Insurance Company and Address:_____

Insured Name:_____ DOB:_____ Relationship to Patient:_____

Member ID:_____ Group #:_____

Medical History

Reason for visit today: _____

Height:_____ Weight:_____ Shoe Size:_____

Primary Care Physician: _____ Phone #: _____

Date you last saw your primary doctor:_____

Are you currently taking any medication? ☐No ☐Yes, Please list below:

_____
_____
_____

Allergies? ☐No ☐Yes, Please list Below:

_____
_____
_____

Past Surgical History: _____

_____

Patient's Current and Past Medical History (check all that apply): ☐ **NONE**

☐A-Fib ☐Anemia ☐Anxiety ☐Arthritis ☐Asthma ☐Back Pain ☐Bleeding Disorders ☐Cancer

☐Defibrillator ☐Depression ☐Diabetes ☐Eczema ☐Epilepsy ☐Fibromyalgia ☐Gout

☐Heart Disease ☐Hepatitis ☐High Blood Pressure ☐Kidney Disease ☐Liver Disease ☐Lung Problems

☐Neuropathy ☐Osteoarthritis ☐Osteoporosis ☐Osteopenia ☐Pacemaker ☐Psoriasis

☐Radiation/Chemo ☐Raynaud's ☐Seizures ☐ Stroke ☐Thyroid Disease

☐Other: _____

Authorization to Disclose Health Information

I authorize Central Dupage Foot and Ankle Associates, P.C. to discuss my medical care with the following:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Acknowledgment of Receipt of Notice of Privacy Practices and Billing Authorization

I hereby acknowledge that I received a copy of Central Dupage Foot and Ankle Associates Medical Information Privacy Notice for my review prior to receiving services.

I verify that the above information is true to the best of my knowledge. I hereby give my permission to Central Dupage Foot and Ankle Associates, P.C., to perform diagnostic, therapeutic and/or operative procedures as may deemed necessary in diagnosis and/or treatment of my feet and/or ankles.

Cancellation Policy:

In order to serve you better and keep the cost of medical care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments. **We need at least 24-hour notice for any cancelled appointment. We will waive the cancellation fee of $50 if it is your first cancellation or if it is a true emergency. We will charge you if it happens a 2nd time. After 3 of these cancellations without proper notice, you may be dismissed from our office or a deposit of $100 will need to be obtained before making another appointment.**

Collection Policy:

We also reserve the right to send an account to collections. We will make several attempts before doing so, via statements and phone calls. If the account goes into collections, a deposit of $100 **in addition to the balance** will need to be paid before another appointment can be made. The deposit amount will be refunded once claim is paid in full.

SIGNATURE OF PATIENT/GUARDIAN_____

PRINT NAME:_____ **DATE:** _____

RELATIONSHIP TO PATIENT:_____