Website: Footillinois.com
Phone: (630) 495-FEET (3338)

MIDWEST
FOOT & ANKLE
SPECIALISTS

• Dr. Christopher Cklamovski • Dr. Mark Spaccapaniccia • Dr. Christine Heck

Midwest Foot & Ankle Specialists

NAME _____
LAST FIRST

ADDRESS _____
STREET APT # CITY STATE ZIP

HOME PHONE ( ) CELL PHONE ( ) EMAIL _____

AGE BIRTHDATE SOCIAL SECURITY # _____

SEX ☐ M ☐ F HEIGHT WEIGHT SHOE SIZE _____

YOUR OCCUPATION EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMERGENCY CONTACT NAME PHONE ( ) _____

MARITAL STATUS ☐ S ☐ M ☐ W ☐ D NAME OF SPOUSE _____

DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO **Please bring your ID & Insurance card(s) to every visit.**

NAME OF PRIMARY INSURANCE _____

NAME OF SECONDARY INSURANCE _____

IS IT YOUR INSURANCE POLICY? ☐ YES ☐ NO IF NO, WHOSE POLICY IS IT? _____ THEIR BIRTHDATE? _____

GUARANTOR (RESPONSIBLE PARTY FOR THIS ACCOUNT OR CUSTODIAL PARENT) ☐ Self ☐ Other

GUARANTOR NAME _____
LAST FIRST

ADDRESS _____
STREET APT # CITY STATE ZIP

PHONE ( ) BIRTHDATE SOCIAL SECURITY # _____

*If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility .

All unpaid balances and/or denied claims are your responsibility.

PRIMARY CARE PHYSICIAN'S NAME _____

PRIMARY PHYSICIAN PHONE OR ADDRESS DATE OF LAST VISIT _____

REASON FOR VISIT? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____ HAVE YOU BEEN TREATED FOR IT? ☐ YES ☐ NO

NAME OF PHYSICIAN PREVIOUSLY TREATED BY: _____

IS YOUR FOOT PROBLEM THE RESULT OF A WORK-RELATED INJURY? ☐ YES ☐ NO

MEDICAL INFORMATION

PAST MEDICAL HISTORY

Have you every had the following?

☐Measles	☐Cancer	☐High Blood Pressure	☐Psychological Problems
☐Mumps	☐Cataract	☐Low Blood Pressure	☐Seizure
☐Chickenpox	☐Cellulitis	☐Hearing Loss	☐Sexually Transmitted Disease
☐Rheumatic Fever	☐Circulatory Disorders	☐Hepatitis _____	☐Skin Problems
☐AIDS or HIV+	☐Diabetes	☐Kidney Disease	☐Stroke
☐Anemia	☐Digestion Problems	☐Liver Disease	☐Swelling of Feet/Ankles
☐Arthritis	☐Dizziness	☐Migraine Headaches	☐Tuberculosis
☐Asthma	☐Ear/Nose/Throat Problems	☐Numbness/Tingling	☐Thyroid Disease
☐Balance Problems	☐Epilepsy	☐Pacemaker	☐Ulcer Stomach/Skin
☐Bladder Problems	☐Fainting	☐Pneumonia	☐Varicose Veins
☐Blood/Plasma Transfusions	☐Fevers over 103°	☐Polio	☐Vision Problems
☐Bowel Problems	☐Heart Disease	☐Prolonged Bleeding	☐Other _____

FAMILY HISTORY

Has anyone in your family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

☐Heart Disease _____	☐Cancer _____	☐Diabetes _____
☐Circulatory Disease_____	☐Hypertension_____	☐Arthritis _____
☐Neurological Problems_____	☐Skin Disease_____	☐Foot Problems _____

Additional space, if necessary:_____

LIST ANY MEDICATIONS AND DOSAGE:

_____

_____

PREVIOUS HOSPITALIZATIONS AND SURGERIES:

_____

_____

ALLERGIES

Do you have a history of skin reaction or other adverse reaction to:

☐ Anesthetics	☐ Environmental Substances	☐ Pain Medication	☐ Sulfa
☐ Antibiotics	☐ Foods	☐ Penicillin	☐ Tape
☐ Aspirin	☐ Iodine	☐ Seasonal Allergies	☐ Tetanus
☐ Codeine	☐ IV Dye	☐ Silver	☐ Other_____

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctors office of any changes in my medical status. I, hereby, give my permission to Spaccapaniccia Podiatry D/B/A Midwest Foot & Ankle Specialists to diagnose and administer treatment of my podiatric foot, ankle and/or related systemic and lower leg condition(s).

SIGNATURE _____ DATE _____ REVIEWED BY _____

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PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby consent to the treatment provided by Doctors Cklamovski, Spaccapaniccia, Heck and its employees or designees. I authorize the physical health care services deemed necessary or advisable by caregivers to address my needs.

INITIAL _____

CONSENT FOR PHOTOGRAPHS

I grant permission for photographs to be taken to assist in documenting my condition.

INITIAL _____

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, of for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

INITIAL _____

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE

I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for an covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collecting including reasonable attorney's fees.

INITIAL _____

PRIVACY POLICY

I acknowledge having received the Practice's, "Notice of Privacy Policies." My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent.

INITIAL _____

_____

PATIENT OR AUTHORIZED PERSON SIGNATURE RELATIONSHIP DATE