

LAKE IN THE HILLS PODIATRY

NEW PATIENT REGISTRATION & MEDICAL HISTORY

PATIENT INFORMATION

Date: _____ Patient Name (Last, First, MI): _____

Date of Birth: _____ Sex: ☐ M ☐ F: _____

Address / City / State / ZIP: _____ Primary Phone / Alternate Phone: _____

Email _____

Emergency Contact / Relationship _____

Emergency Contact Phone _____

INSURANCE & RESPONSIBLE PARTY

Primary Insurance / Member ID _____

Group / Policy # / Subscriber _____

Secondary Insurance / Member ID _____

Responsible Party (if different) / Relationship _____

REASON FOR TODAY'S VISIT

Chief complaint / reason for visit _____

MEDICAL HISTORY

Check any condition you currently have or have had in the past:

- ☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ Circulation problems
- ☐ Kidney disease ☐ Liver disease ☐ Neuropathy ☐ Arthritis
- ☐ Lung disease ☐ Stroke ☐ Bleeding disorder ☐ Cancer
- ☐ History of blood clots ☐ Other significant condition

Other / details _____

Last flu shot _____

MEDICATIONS & ALLERGIES

List all prescription medications, over-the-counter medicines, vitamins and supplements, including doses when known.

Medication allergies / reaction _____

Pharmacy: _____ Pharmacy location _____

SURGERIES / HOSPITALIZATIONS

Surgeries or hospitalizations (include approximate dates if known)

PRIMARY CARE & OTHER CARE

Primary Care Physician / Practice _____

Last visit (if known) / Other physicians treating you _____

PODIATRIC / FOOT HISTORY

- ☐ Athlete's foot ☐ Heel pain ☐ Bunions ☐ Corns/calluses ☐ Ingrown toenails
- ☐ Flat feet ☐ Plantar warts ☐ Ankle pain ☐ Swelling ☐ Numbness
- ☐ Cramping ☐ Other foot problem

Tobacco use (current / former / never) _____

Patient/Guardian Signature: _____ Date: _____

LAKE IN THE HILLS PODIATRY

CONSENT FOR TREATMENT, INSURANCE & FINANCIAL RESPONSIBILITY

CONSENT FOR EXAMINATION AND TREATMENT

I consent to examination, evaluation, diagnosis and treatment by Lake in the Hills Podiatry and its physicians, employees and clinical staff. I understand that the nature of my condition, recommended treatment, risks, benefits and alternatives will be explained to me as appropriate. I may ask questions and may refuse treatment to the extent permitted by law.

AUTHORIZATION TO BILL INSURANCE / ASSIGNMENT OF BENEFITS

I authorize Lake in the Hills Podiatry to submit claims to my health insurance plan for services provided to me and to receive payment directly from my insurer when permitted by my plan. I authorize the release of information reasonably necessary to process claims, obtain payment, determine benefits, and coordinate care. I understand that insurance verification is not a guarantee of payment and that my insurance plan determines coverage and benefits.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible for amounts that are my responsibility under my insurance plan, including applicable deductibles, copayments, coinsurance and other amounts lawfully due for services provided. I understand that I may also be responsible for services that are not covered by my insurance when I have been informed of the applicable charge or responsibility as required by law. I agree to provide accurate and current insurance and demographic information and to notify the practice of changes.

I understand that the practice cannot guarantee that my insurance company will pay a claim. If my insurer denies or reduces payment for a service, the practice will process the claim and applicable appeal/administrative steps according to its policies and my insurance requirements; any amount legally assigned to me remains my responsibility. I understand that this agreement does not require me to pay amounts that applicable law or my insurance contract prohibits the practice from billing me.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided or offered a copy of Lake in the Hills Podiatry's Notice of Privacy Practices and have been given an opportunity to review it. I understand that the Notice explains how my health information may be used and disclosed and describes my privacy rights.

COMMUNICATION PREFERENCES

☐ Call ☐ Text ☐ Patient portal ☐ Voicemail permitted

Preferred phone: _____ Preferred email: _____

May we discuss your medical condition or information, including appointments with any member of your family?

If yes, please list name: _____

PATIENT / RESPONSIBLE PARTY ACKNOWLEDGMENT

By signing below, I confirm that the information I have provided is accurate to the best of my knowledge. I have read and understand the Consent for Treatment, Authorization to Bill Insurance, Financial Responsibility Agreement, and Notice of Privacy Practices acknowledgment above.

Patient / Guardian / Responsible Party Signature: _____

Printed Name: _____ Relationship: _____

Date: _____