

PODIATRIST FIRST VISIT FORM

DATE _____ **Patient Full Name:** _____

Date of Birth: _____ Sex: _____ SSN: _____

Patient Address: _____

City, St, Zip: _____

Race / Ethnicity: (Check One) 1 American Indian or Alaska Native 2. Asian 3. Black or African American 4. Hispanic or Latino 5. Native Hawaiian or Other Pacific Islander 6. White 7. Other _____

Preferred Language _____

Patient Home Phone: _____ Cell: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Family Doctor's Name: _____ Phone: _____

Address _____ Last Visit Date _____

Chief Complaint (reason for seeing a Podiatrist) _____

Have you ever been to a Podiatrist Before – Yes No

If Yes, please list: Name _____ Date of Last Visit _____

Is there any personal or family history of diabetes – Yes No

Your occupation _____

Cigarette/ Tobacco Use – Yes No Years Smoked _____

Athletic activities in which you participate (please list and indicate frequency) _____

Place a mark on “Yes” or “No” to indicate if you have had any of the following:

AIDS/HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies to Anesthetics	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies to Medicine/Drugs	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Foot or Leg Cramps	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/>
Angina	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gout	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Special Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valves or Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemophilia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swelling of Ankles, Feet	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis or Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Neck Glands	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tired Feet	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemical Dependency	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Varicose Veins	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Neuropathy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Circulatory Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Phlebitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weight loss unexplained	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Taking Contraceptives	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ear Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Surgeries you have had _____

Hospitalizations other than for surgeries listed _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins (attach a list if present) _____

Pharmacy Name(s) _____ **Pharmacy Phone(s)** _____

ALLEGRIES

Adhesive / Tape	Yes <input type="checkbox"/> No <input type="checkbox"/>	Local Anesthetics	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anticoagulant Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Novocaine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Aspirin	Yes <input type="checkbox"/> No <input type="checkbox"/>	Penicillin	Yes <input type="checkbox"/> No <input type="checkbox"/>
Codeine	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seafood	Yes <input type="checkbox"/> No <input type="checkbox"/>
Demerol	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sulfa	Yes <input type="checkbox"/> No <input type="checkbox"/>
Iodine	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other _____	

INSURANCE INFORMATION

(Please have all Insurance Cards and Id with you during visit)

InsuredName _____
Primary Insurance Company Name _____
Insurance ID# _____ Group # _____
Claims Address _____ City State Zip _____

SUPPLEMENTAL/ SECONDARY INSURANCE

InsuredName _____
Secondary Insurance Company Name _____
Secondary Insurance ID# _____ Group# _____
Claims Address _____ CityStateZip _____

PATIENT CONSENT FOR TREATMENT

I, _____ hereby give my permission to Dr. Rabinovich D.P.M. and his staff and associates to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot-ankle condition(s).

AUTHORIZATION TO RELEASE INFORMATION

I, _____ hereby authorize Dr. Rabinovich to release any medical information pertaining to my treatment and permit any insurer to inspect my medical records in connection with charges arising from this treatment in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all its provisions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

FINANCIAL POLICY:

I, _____ hereby authorize payment of medical benefits to Dr. Rabinovich for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-pays, deductible, and non-covered services if any. If you do not have insurance, the total agreed upon with the doctor cost of your visit is required at the time of service. Should you default on your required payment, collection action is possible.

_____ I have read and accept the financial policy of Absolute Medical Care & Absolute Foot and Ankle Clinic. I authorize payment of medical benefits to the named provider for professional services rendered.

Patient Name: _____

Signature of Adult over 18: _____

Relationship to Patient: _____ **Date:** _____

Absolute Medical Care
20637 W. Renwick Rd. Crest Hill IL 60403
815-838-9505

Absolute Foot & Ankle Clinic
3546 N. Milwaukee Avenue Northbrook IL 60062
847-297-9660