First MI Last | Preferred Name | Job Activity / Occupation

Birth Date | M / F Sex | Age | Height | Weight | Shoe Size

Medications: Please list:

	Dose?	How Often? (daily, weekly)	For Treatment of?
		X D, W	
		X D, W	
		X D, W	
		X D, W	
		X D, W	

Preferred Pharmacy:

City:

Allergies (such as latex, adhesive Tape, antibiotics, Iodine): _____

List relationship of family members who have had:

Diabetes: _____ Foot Problems: _____
Arthritis: _____ Heart Attack: _____
Stroke: _____ High Blood Pressure: _____
Cancer: _____ Birth Defects: _____

# of childbirths ____ Currently Pregnant? ☐Yes ☐No
Are you slow to heal after cuts? ☐Yes ☐No
Do you smoke now? ☐No ☐Yes Packs/day___ Years ___
Did you ever smoke? ☐No ☐Yes Packs/day___ Years ___
If you quit when did you do so? _____
Alcoholic Beverages: (circle one) None Rarely Moderately Daily Quit

Does foot pain limit your desire activities? ☐Yes ☐No
Do you have any difficulty in walking? ☐Yes ☐No
Any pain in calves or buttocks when walking? ☐Yes ☐No
Is the pain relieved by stopping & standing still? ☐Yes ☐No

Did you previously or do you now wear:
Shoe Inserts? _____ Did they help? _____
Orthotics? _____ Did they help? _____

List the sports/dance you are active in:

Are your first steps out of bed painful? ☐Yes ☐No ... then subsides? ☐Yes ☐No
Do you get leg cramps...during the Day? ☐Yes ☐No ...at Night? ☐Yes ☐No
Percent of waking hours spent on your feet? 20 40 60 80 100

Do you have grafts, implants, or heart valves? ☐Yes ☐No
Have you had any other serious illness? ☐Yes ☐No
Have you had any surgery or hospitilizations? (if yes, please list below)

Surgery/Hosp. For?	Date	Complications?

Do you have or have you ever been treated for:

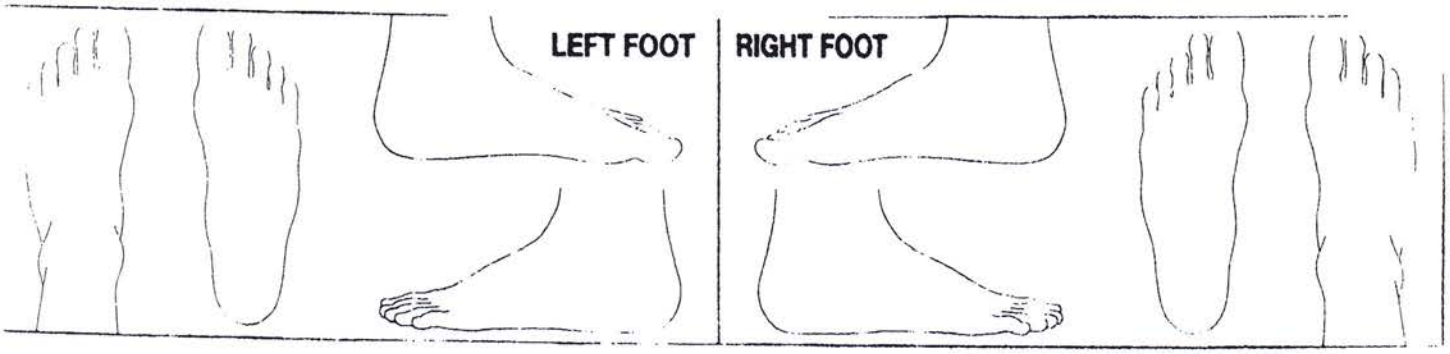
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Poor Circulation
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Lyme's Disease
- ☐ Headaches
- ☐ Nerve Disorder
- ☐ Lung Disease
- ☐ HIV
- ☐ Chronic Light Stool
- ☐ Unexplained Weight Loss
- ☐ ***NONE** of these*
- ☐ Heart Attack
- ☐ A Heart Condition
- ☐ Diabetes
- ☐ Keloid/ Thick Scar
- ☐ Alzheimer's
- ☐ Rheumatic Fever
- ☐ Hearing/Ear Disorder
- ☐ Psychiatric Disorder
- ☐ Tuberculosis
- ☐ Liver Disorder
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Anemia
- ☐ Eyes: Glaucoma/Manicular Deg.
- ☐ Gout
- ☐ Sciatica
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Asthma
- ☐ Hepatitis
- ☐ Thyroid Problem
- ☐ Stomach Ulcer
- ☐ Others: _____

Anything else that you want to tell the doctor? ☐ **Yes** ☐ **No**

_____

_____

Family/Primary Physician: _____ City: _____ Date Last Seen: _____



Please mark the location of your first problem or pain on the diagrams above with a **1.**
Describe your problem below and its cause if you know. Please describe associated pain to the right. ➡

My first problem is... ☐ Left ☐ Right ☐ Both
It causes me difficulty: ☐ walking ☐ wearing shoes
And/or: _____

_____

Is the problem work related? ☐ Yes ☐ No
How long ago did the problem start? _____

Is your pain / discomfort:
☐ None ☐ Light ☐ Moderate
☐ Strong ☐ Severe

****

- ☐ Shooting
- ☐ Throbbing
- ☐ Sharp
- ☐ Burning
- ☐ Dull
- ☐ Itching
- ☐ Aching
- ☐ Tenderness
- ☐ Tingling
- ☐ Numbness

Previous treatments/remedies?

_____

Are there any other problems? _____

Signature: _____ **Date:** _____

Patient Registration

Date: _____

Patient's Full Name:_____ Preferred Name: _____

Mailing Address:_____ City:_____ St:_____ Zip:_____

Home Telephone:_____ Cell Phone: _____

Birth Date: _____ Age:_____ Sex: Male Female

Social Security:_____ Marital Status: S M D W Separated

Employer:_____ Position:_____ Phone Number:_____

Employer Address:_____ Full / Part Time

Spouse Name:_____ Spouse Employer:_____

Emergency Contact:_____ Phone Number:_____

How did you hear about our office: Please circle all that apply.

Newspaper Yellow Pages Radio Friend/Relative

Insurance Physician: _____ (Please list name of physician)

FILL OUT ONLY IF PATIENT IS UNDER 18

Guarantor's Name:_____ Relation to Patient:_____

Guarantor's Address (if different from above):_____

Guarantor's Date of Birth:_____

Insurance Company:_____ Copay:_____

Insurer's Name:_____ Insurer's Date of Birth:_____

Insurer's Social Security Number:_____

The above information is accurate and complete to the best of my knowledge and Is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of the form. I understand responsibility for payment is mine, payable at the time service is rendered. I further understand attorney fees, court cost and collection service fees incurred in the collection of this account are my responsibility. I also assign insurance benefits to the doctor.

Signature:_____ **Date:**_____

James C. Graham, DPM, FACFAS, FACFAOM
900 West Temple, Suite 202
Effingham, IL 62401
(217) 342-2040

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____

Date of Birth: _____

I request that ALL communications to me (by telephone, mail or otherwise) by Dr. James C. Graham and/or his staff be handled in the following manner.

For WRITTEN communications: Address to: _____
_____
_____
_____

For ORAL communications: Call: _____
(telephone number)

May we leave a message:
YES_____ NO_____

Name of person(s) that can obtain information about your medical history/information or your account/billing information. I understand the person(s) listed below will be the ONLY individuals to be able to obtain medical and/or account information.

NAME	RELATIONSHIP	MEDICAL	BILLING
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____
Patient Signature **Date**

For Practice Use Only

Practice_____ Accepts _____ Denies

Entered By:_____ Date:_____

Billing Policies for Dr. James Graham

We will bill your insurance as a courtesy at the time of your initial visit, a new patient is required to pay in full the charge for the office visit and additional charges (x-rays, procedures) unless the patient has insurance with A COPAY or a percentage of total charges are required. Financial agreements may be set up with the office manager should this not be possible. Statements will be mailed on a monthly basis, with all balances reflecting payments made throughout the month.

This office will bill each patient's primary insurance carrier. Patients should be aware of their insurance coverage and be able to estimate the amount of charges that the insurance company will determine to be the patient's share. That amount should be paid upon the receipt of each statement. Despite this, the patient is responsible for the entire balance due regardless of whether the insurance company is billed or pays any portion of the balance. Payment in full is expected in three months. An interest charge of 1.5% will be added after charges are outstanding for longer than 60 days.

Insurance policies are CONTRACTUAL AGREEMENTS between PATIENTS AND INSURANCE COMPANIES. We are, therefore, not able to answer questions regarding specific coverage, but will offer assistance in understanding of any activity by the insurance company reflected in the patient's account. It is not our policy or our responsibility to contact insurance companies to determine coverage in advance or to establish the reasoning behind insurance payments which are less than expected. Patients should keep in touch with their insurance companies to determine the status of any unpaid claims which have been billed by our office. Also, it is the patient's responsibility to question this office participation in any HMO's or PPO's. We are not responsible for any restrictions or requirements set forth by any HMO's or PPO's if we are not under contractual agreement with that company.

If you are claiming a Workers Comp case against your employer, you must have the name of the Insurance Company, claim number, and a contact person. If you do not have this information YOU will be responsible for the account.

This office DOES NOT accept Medicaid patients. Patients will be responsible for the balance in full at the time of the visit.

RESPONSIBLE PARTY: We understand court decisions sometimes mandate responsible party following a divorce. In situations such as this, we ask that the representing parent/party pay for the co-payment/deductible at the time of the service. We will provide a receipt for reimbursement purposes.

There may be a FEE for the completion of disability forms, mortgage forms, auto insurance forms and bank forms of all types. Similarly, a fee will be assessed for the provision of copies of medical records in certain circumstances. These fees must be paid before the forms are completed. We regret this additional charge, but the number of forms completed has become overwhelming and requires considerable staff time.

This office DOES NOT participate in fraudulent practice of writing off the amount considered to be the patient's portion after payment has been received from the insurance company.

By signing below, (1) you promise to pay the account; (2) state that you are the patient or the legal guardian or parent of the patient; (3) you authorize and direct all insurance companies to send payment directly to James C. Graham, DPM; (4) agree if any insurance company pays you directly for services you will pay the money immediately to Dr. Graham; (5) if you fail to promptly pay the balance in full, provider may employ an attorney or collection agency to collect the balance due and legal fees and expenses will be added to the account balance owed. If you have any questions regarding our office policies or wish to make special billing arrangements, please feel free to contact our office manager.

"I have read this entire form and the terms contained in it and believe I understand it. I am signing it of my own free will and authorize the Provider to release medical information from my file for any reasonable purpose involving the processing of claims/payments."

_____ _____

Signature of Responsible Party for this Account **Date**