Welcome to our Practice
Robert A. Raley DPM, SC
70 Meadowview, Suite 401
Kankakee, Illinois
815-932-1724

Today's Date_____ **Date of Birth**_____

Patient's Name _____

Patient Social Security Number_____ **Marital Status**_____

Address_____

_____

Primary Phone Number_____ **Is this a cell phone?** Yes ____ No_____

Secondary Phone Number_____ **Is this a cell phone?** Yes_____ No_____

Would you like to receive text messages for appointment reminder from us? Yes_____ No_____

Place of Employment_____ **Work Phone Number**_____

Email Address_____

Spouse's Name_____ **Date of Birth**_____

Address_____

_____

Spouse Phone Number_____

Place of Employment _____**Work Phone Number**_____

Emergency Contact Person_____**Relationship**_____

Emergency Contact Person Phone Number_____

Primary Care Physician_____

Date Last Seen Primary Care Physician if you are diabetic _____

What is your main concern today? Include any foot, ankle, thigh and hip complaints.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Which Foot is bothering you? Right _____ Left _____ Both _____

Circle all foot problems

Ankle Problem	**Fracture/Sprain**	**Neuroma**
Athlete's Feet	**Fungus**	**Numbness in Feet or Legs**
Bunions	**Gout**	**Plantar Warts**
Corns/Calluses	**Hammertoe**	**Swelling of Feet or Ankles**
Cramps in Feet or Legs	**Heel Pain**	**Tired Feet**
Diabetic Ulcer	**High Arches**	
Flat Feet	**Ingrown Toe Nail**	

Have you been to another Podiatrist within the past 2 months for routine foot care? _____

If yes what date were you last seen by another Podiatrist? _____

What athletic activities do you participate in? _____

Height _____ Weight _____

How did you hear about us?

Phone Book _____ Internet _____ Word of Mouth _____

Whom may we thank for recommending us? _____

Patient Name_____ **Date**_____

Social History

Do you smoke cigarettes? Yes _____ **No** _____ **How many per day?** _____

Are you a former smoker? Yes _____ **No** _____ **Do you chew tobacco?** _____

List all past surgeries or hospitalizations:

_____

_____

_____

_____

_____

_____

_____

Circle All Medical Conditions You Have

Epilepsy/Seizures	Parkinson
Arthritis/Rheumatoid Arthritis	Bone Disease
Diabetes	Skin Disease/Eczema/Dermatitis
Liver condition/High Cholesterol/Hepatitis	Lupus
High/Low Blood Pressure	Fibromyalgia
Heart Problem	Neuropathy
Stroke	Intellectual Disorder
Thyroid Condition	Anemia
Kidney Condition	Blood Clots
Cancer/Tumors	Acid Reflux
Asthma/COPD	Bleeding Tendencies
Alzheimer/Dementia	Hay Fever
HIV/AIDS	Psychiatric/ Nervous Disorder

Family History

Is your mother living?____ or deceased?__

Did/Does your Mother have any Medical Conditions? What are they?

Is your Father living?_____ or deceased?__

Did/Does your Father have any Medical Conditions? What are they?

Medications

Are you taking medications? Yes____ No___ (If yes, please give us a medication list)

If you don't have a medication list, please list your medications and dosages._____

Are you allergic to any medications Yes____ No ____

List all medicines that you are allergic too and the reaction that you had when taking it:

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We at Dr. Raley`s office are committed to providing you with the best possible care. If you have Medical Insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and understanding of our payment policy.

Unless insurance arrangements have been approved in advance by our staff, payment for services is due at the time services are rendered. We accept payment in the form of cash, check, and most credit cards.

Insurance is a contract between you and your insurance company. You are responsible for informing this office of any changes in coverage.

1. Our fees fall within the usual, customary, reasonable fees for this region.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.

3. Medicare Patients: We would like you to understand that taking assignment which means that you are responsible for the yearly deductible and for the 20% (co insurance) of what Medicare allows. You are also responsible for services that Medicare or your co-insurance doesn't cover.

The filing of insurance claims is a courtesy that we have always extended to our patients. However, all charges are your responsibly, not your insurance company. We will make our best effort to collect from them, but if we are not successful, you are responsible for the unpaid balance. You also give us permission to check your insurance for eligibility.

By signing below, you authorize payment of medical benefits to be made on your behalf to Dr. Raley for any services furnished to you or those for whom you are responsible. Your signature below also verifies you understand our financial policy, have read and understand our privacy practice brochure, and give permission to Dr. Raley to administer and or perform such procedures as may be deemed necessary in the diagnosis and or treatment of the extremity condition.

Patients Name_____

Responsible Party if not patient (Please Print) _____

Signature_____ Date_____

I agree to the following terms and conditions: I am responsible for all fees due to collection proceedings including, but not limited to: attorney fees and court costs incurred by creditor. There is a 1.5% monthly late charge assessed on all balances after 90 days past due. I agree to pay a collection fee of 30% of the total owed when sent to collections. I have read and understand the above paragraph. Non-sufficient funds checks are subject to a $25.00 service fee.

I have read and understand the above paragraph in its entirety.

Signature_____ Date_____