WELCOME TO OUR OFFICE! ***TODAY'S DATE**_____

***Patient Name:** _____
Last **First** **Middle**

Home Address: _____

City: _____ State:_____ Zip Code:_____-_____

Phone #: Home (____) _____Work: (____) _____Cell: (____)_____

*Sex:_____ *Birth Date:_____ *Marital Status:_____

*E-Mail Address: _____

Personal Contact Preferences: Home/Cell Mail E-Mail

Primary Language:_____ Race:_____ Ethnicity:_____

Primary Physician (Full Name):_____

How did you learn about our office? Please circle **One Choice:**

Previous Patient Referral	Digital Sign	Yellow Pages	Reputation
Relative/Spouse/Friend	Radio/TV	Insurance/Website	Building Sign
Cortese Web Site	Internet	Shoe Store	Hospital/Emergency Room
Cinema/Movie Theater	Doctor	Healthy Cell Publication	Other:_____

If referred by Dr. (Please list Dr.'s Full Name): Dr._____City:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact phone #: Home_____or Work/Cell:_____

EMPLOYMENT

Employer:_____Employment status: FT_____PT_____

Employer's Address:_____City:_____Zip:_____

Employer's Phone # (____)_____

Student ____Yes ____No Student Status: Full-time or Part-time Retired: Yes or No

*Indicates information that we are required to obtain from our patients. Thank you for your cooperation.

Complete this section only if someone other than the patient is responsible

Responsible Party:_____ Relationship to Patient: _____

Address: _____ E-Mail:_____

City: _____ State: _____ Zip:_____

Phone: (____) _____ Birth date: _____

CORTESE FOOT AND ANKLE
1607 Visa Drive, Suite 5B
Normal, IL. 61761

ACKNOWLDEGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____

Patient Name (Please Print)

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read it if I chose) and understand the Notice.

Is there anyone else you give us permission to discuss your health care issues or to leave messages with about appointments until you give us written notice otherwise? _____Yes _____No

NAME_____ NUMBER_____ RELATIONSHIP_____

NAME_____ NUMBER_____ RELATIONSHIP_____

NAME_____ NUMBER_____ RELATIONSHIP_____

_____ DATE _____

Patient signature

CORTESE FOOT AND ANKLE CLINIC, P.C.

CONSENT / ASSIGNMENT/ RELEASE / AGREEMENT TO PAY

1607 Visa Drive, Suite 5N
Normal, Illinois 61761
Ph: **(309) 452-3000;** Fax: **(309) 452-3668**

In consideration of the treatment if Applicant as a patient of the above mentioned, the person signing this form below ("Undersigned) agrees as follows:

1. AUTHORIZATION FOR MEDICAL TREATMENT: The undersigned hereby authorized the physician assigned as provided by law to furnish medical treatment or to administer whatever anesthetics as he considers necessary and proper in the treatment of patient for the purpose of correcting his/her physical condition

2. RELEASE OF INFORMATION: The undersigned hereby consent that information contained in Patient's financial and medical records and (when specifically requested) copies of any pertinent medical record information may be given to relevant: Cortese Foot and Ankle Clinic, P.C. owned and/or affiliated facilities, or insurance companies or other third party payors. The Undersigned also recognize that Patient's medical records may also contain medical information concerning mental health, developmental dis-ability, alcohol abuse, drug abuse, and or AIDS and HV test results and information. This Release of Information section of this Agreement may be revoked at any time except tot he extent Cortese Foot and Ankle Clinic, P.C has already taken action on its reliance on this release. This consent is valid for five years from the date the Patient is discharged. The Undersigned further consent that Cortese Foot and Ankle Clinic, P.C. may access and retrieve credit information regarding the Patient and the Undersigned from any licensed credit bureau.

3. ASSIGNMENT OF BENEFITS: The Undersigned hereby irrevocably assign Cortese Foot and Ankle Clinic, P.C.. any and all rights which they have against any insurance company or other third party payor for payment of the Patient's bill to Cortese Foot and Ankle Clinic, P.C. The Undersigned authorize the application of any overpayment to any unpaid bill at the Cortese Foot and Ankle Clinic, P.C. for which the Patient is responsible that has not been paid in full at the time of the over payment.

4. PAYMENT: To the extent not paid by the Patient's insurer or other third party payor(s) within 30 days from the date of first billing, the Undersigned promise to pay upon demand, unless other arrangements are approved in writing by Cortese Foot and Ankle Clinic, the full outstanding balance for Cortese Foot and Ankle Clinic's actual charges for goods and services provided to the Patient at the rates set forth in the Cortese Foot and Ankle Clinic Charge Master ("Price List:) as in effect at the time of admission or scheduled at the time of admission to go into effect during Patient's anticipated stay, which is hereby incorporated by reference and made a part of this Agreement. The Undersigned acknowledge that they have been given the opportunity to review the Price List and have reviewed the Price List or expressly declined to do so. If Cortese Foot and Ankle Clinic has agreed to accept payment for services provided to the Patient under a different contract such as, but not limited to, Medicare, Medicaid, or a preferred provider agreement, the foregoing provisions shall not apply, and the Undersigned shall pay the amounts which are the responsibility of the Patient under such separate contract.

5. GOODS AND SERVICES: The Undersigned acknowledge that the Patient will receive goods and services from Cortese Foot and Ankle Clinic during the visit as ordered by the Patient or the Patient's attending physician or other treating physician as agent for the Patient. Payments for all such goods and services shall be made as provided above.

6. MISCELLANEOUS: If the Undersigned is not the Applicant, the Undersigned represent and warrants that they have full legal authority to sign this Agreement on behalf of the Applicant. All individuals signing this Agreement as the Undersigned shall have joint and several liability for all amounts due hereunder, the Cortese Foot and Ankle Clinic may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The Undersigned promise to pay all costs of collection, including reasonable attorney's fees, costs, and court costs, which are incurred by Cortese Foot and Ankle Clinic in enforcing payment after default. This agreement and the obligations, consents and information releases contained herein shall be binding upon the Patient's heirs, executors, and administrators.

NOTICE TO UNDERSIGNED

1. Do not sign this Agreement before you read it.
2. The Undersigned hereby acknowledges receipt of a copy of this Agreement.
3. Independent groups of physicians: i.e., anesthesiologist, radiologists, and pathologists have entered into agreement with Cortese Foot and Ankle Clinic for provision of specialized services. The physicians in these groups are <u>not employed nor agents of Cortese Foot and Ankle Clinic</u>. Additionally, consulting physicians who see you during your visit are not employees or agents of Cortese Foot and Ankle Clinic.
4. All terms of this agreement are valid for five years from date of signature.

Dated:_____ Signature:_____

PATIENT INFORMATION SHEET

Name:_____ Date:_____

Chief Complaint:_____

Duration:_____ Which foot? ____R ____L ____Both feet

Is the chief complaint a result of an injury? ____Yes ____No

What is your treatment goal? ____Diagnosis ____Pain relief only ____Correction

____Other:_____

Past Medical History:

___Allergy
___Asthma
___Anemia
___Anxiety
___Arthritis/Gout
___Arthritis/Rheumatoid
___Blood Disorder
___Cancer
___Depression
___Diabetes, if yes, A1c___
Type I:___/Type II:___
___Other:_____
___Encephalitis
___Frequent Urination
___Heart Disease
___High Blood Pressure
___High Cholesterol
___Immune System Disorder
___Liver Disease (hepatitis/cirrhosis)
___Lung Disease
___Meningitis
___Mental Illness
___Nerve Problem in legs
___Nerve Problem in legs
___Osteoporosis
___Phlebitis
___Poor circulation in legs
___Rheumatic Heart Disease
___Seizure/Convulsions
___Stroke
___Thyroid Disease
___Tuberculosis
___Ulcer, foot, leg

Drug Allergies: Name of Drug(s)

_____
_____
_____
_____

Describe Drug Reaction:

_____
_____
_____
_____

Marijuana or CBD usage: **Recreational ____** **Medically Treated____**

Medications & vitamins(use extra page if needed)

_____
_____
_____
_____

Surgical History:

_____
_____
_____
_____

Height_____ **Weight_____** **Shoe size_____**

Social history:

Tobacco: ____Yes ____No ____Quit Amount per day:_____ How many years?____
Alcohol: ____Yes ____No ____Quit Amount per day:_____ How many years?____

Family History:	**Father**	**Mother**		**Father**	**Mother**
Bleeding disorder	_____	_____	Kidney Disease	_____	_____
Cancer	_____	_____	Mental Illness	_____	_____
Diabetes	_____	_____	Osteoporosis	_____	_____
Glaucoma	_____	_____	Seizures/Convulsions	_____	_____
Heart Disease	_____	_____	Stroke	_____	_____
High Blood Pressure	_____	_____	Thyroid Disease	_____	_____

PLEASE CHECK ANY ISSUES YOU ARE HAVING AT THE CURRENT TIME:

CONSTITUTIONAL
- ☐ Abuse or neglect
- ☐ Addiction
- ☐ Anxiety
- ☐ Decreased appetite
- ☐ Chills
- ☐ Fever
- ☐ Headaches
- ☐ Nausea or dizziness
- ☐ Convulsions
- ☐ Dehydration
- ☐ Fainting
- ☐ Unusual fatigue
- ☐ Hot Flashes
- ☐ Major trauma
- ☐ Migraines
- ☐ Night sweats
- ☐ Sleep problems
- ☐ Extreme thirst
- ☐ Vertigo
- ☐ Weight gain
- ☐ Weight loss

CARDIOVASCULAR
- ☐ Ankle swelling
- ☐ Cramping in calves
- ☐ Heart problems
- ☐ Heart Murmur
- ☐ Chest Symptoms
- ☐ Color changes in extremity
- ☐ Pain in legs when walking
- ☐ Cold feet or hands
- ☐ Elevated blood pressure
- ☐ Jaw pain
- ☐ Loss of sensation
- ☐ Pacemaker
- ☐ Pain in left shoulder
- ☐ Shortness of breath
- ☐ Swelling in legs
- ☐ Tightness in chest
- ☐ Varicose veins

ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Cuts take longer to heal
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Dry skin
- ☐ Excess hair growth
- ☐ Recent hair loss
- ☐ Hyperglycemia
- ☐ Menopausal symptoms
- ☐ Unusual extra energy

EARS/NOSE/THROAT
- ☐ Blisters/ ulcers in mouth
- ☐ Bloody nasal discharge
- ☐ Cough
- ☐ Difficulty hearing
- ☐ Difficulty swallowing
- ☐ Dry throat or mouth
- ☐ Nose bleeds
- ☐ Hearing problems
- ☐ Post nasal drip
- ☐ Ringing in the ears
- ☐ Runny nose
- ☐ Sinus pain or congestion
- ☐ Sore throat
- ☐ Stuffy nose
- ☐ Teeth or gum problems
- ☐ White patches in mouth

EYES
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Excessive tearing
- ☐ Holes in vision
- ☐ Macular degeneration
- ☐ Pain or soreness in eyes
- ☐ Reddened eyes
- ☐ Retina repair
- ☐ Trauma to eye
- ☐ Wears contacts or glasses
- ☐ Yellowish appearance to eyes

GASTROINTESTINAL
- ☐ Abdominal discomfort
- ☐ Acid reflux
- ☐ Bards disease
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Upset stomach
- ☐ Excess gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Irritable bowel syndrome
- ☐ Laxative use
- ☐ Rectal bleeding
- ☐ Swallowing difficulties
- ☐ Yellowing of the skin

GENITO-URINARY
- ☐ Bladder spasm
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Currently pregnant
- ☐ Erectile dysfunction
- ☐ Flank pain
- ☐ Herpes
- ☐ Partner diag. With STD
- ☐ Pelvis pain
- ☐ Recent rape / sexual assault
- ☐ Frequency in urination
- ☐ Decreased urination
- ☐ Urinary tract infection

IMMUNIOLOGIC
- ☐ Allergic reaction
- ☐ Environmental allergies
- ☐ Latex allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Gout
- ☐ Hay Fever
- ☐ Hepatitis B carrier
- ☐ Sensitive to dust
- ☐ Sneezing

INTEGUMENTARY
- ☐ Acne
- ☐ Athletes Foot
- ☐ Basal cell carcinoma
- ☐ Blisters
- ☐ Chicken Pox
- ☐ Dermatitis
- ☐ Dandruff
- ☐ Eczema
- ☐ Excessive scar tissue
- ☐ Fungal nails
- ☐ Hypersensitivity of skin
- ☐ Itchy skin
- ☐ Lower leg ulcers
- ☐ Lumps
- ☐ Mole changes
- ☐ Non-healing wound
- ☐ Psoriasis
- ☐ Rash
- ☐ Skin lesion change
- ☐ Thermal burn
- ☐ Tingling sensation

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Foot pain
- ☐ Decreased motion
- ☐ Occasional weakness
- ☐ Heel pain
- ☐ Joint pain/ redness/ swelling
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Stiffness
- ☐ Muscle pain/ tenderness
- ☐ Neck pain
- ☐ Weakness

RESPIRATORY
- ☐ Asthma
- ☐ Breathing difficulties
- ☐ Loss of consciousness
- ☐ Cold-like symptoms
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Use of C-PAP
- ☐ Use of oxygen
- ☐ Wheezing

NEUROLOGICAL
- ☐ Burning
- ☐ Confusion
- ☐ Dementia
- ☐ Facial ticks
- ☐ Head aches
- ☐ History of seizures
- ☐ Impaired coordination and balance
- ☐ Memory loss
- ☐ Multiple sclerosis
- ☐ Numbness
- ☐ Paralysis
- ☐ Parkinson's
- ☐ Neuropathy
- ☐ Stroke / T.I.A.
- ☐ Tremors
- ☐ Uncontrolled movements
- ☐ Weakness due to back / leg problems

PYSCHIATRIC
- ☐ Addiction to alcohol/ drugs
- ☐ ADHD
- ☐ Anger
- ☐ Anxiety
- ☐ Anxiousness
- ☐ Attempted suicide or suicidal behavior
- ☐ Behavioral Disorders
- ☐ Bipolar
- ☐ Claustrophobia
- ☐ Decreased sex drive
- ☐ Depression
- ☐ Disorientation
- ☐ Emotional issues
- ☐ Emotional or mental abuse
- ☐ Forgetfulness
- ☐ Hallucinations
- ☐ Induced Vomiting
- ☐ Irritability
- ☐ Mental status changes
- ☐ Mood swings
- ☐ Nightmares
- ☐ Over reacting
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Physical abuse
- ☐ Poor anger control
- ☐ Poor sleep patterns
- ☐ Rape/ sexual abuse

LYMPHATIC
- ☐ Anemia
- ☐ Lymph node problems
- ☐ Blood clots
- ☐ Blood transfusion
- ☐ Bruises easily
- ☐ Calf pain
- ☐ Swelling in feet / face / hands
- ☐ Leg swelling
- ☐ Night sweats
- ☐ Sickle cell disease
- ☐ Trouble clotting

Cortese Foot and Ankle Clinic, P.C.
1607 Visa Dr, Suite 5B
Normal, IL 61761
PH: 309-452-3000 Fax: 309-452-3668

Medical Release Form

Patient Name_____ Date of Birth___ /___/____
Please print

I hereby consent to release requested information to Cortese Foot and Ankle Clinic, P.C. from my physician's office,_____
Name of physician(s)

____ All Records
____ Specific Records _____
(list specific records above)

Patient Signature:_____Date:___/____/___

MEDICARE (MIPS)

Only patients on **traditional medicare** need to respond to questions below.

Patient Name:_____ Date:___/___/___

- If you are **65 or older**, do you have a Living Will **or** have you designated someone to make medical decisions on your behalf if you become unable to do so for yourself? ____yes ___no
- If you are **65 or older**, have you fallen within the last 12 months? ___yes ___no
  * **If yes**, how many time did you fall? _____ Did the fall(s) result in any injuries Y / N
- If you are **18 or older,** are you a smoker or tobacco user? ____current ____former ____ never
- If you are **18 or older**, what is your current height and weight?
  height_____ weight_____

FOR STAFF ONLY: :

- BP _____ / _____ ___WNL ____ low or high patient referred to PCP _____active diagnosis of hypertension
- BMI ____ 18.5-29.9 ___30 or above ___18.4 or below / Follow up required? ___yes ___ no
  If yes, documented? _____
- A1C (if applicable) 18-75 years old Date:_____ Result:_____