Great Lakes Foot and Ankle Institute

Medical & Surgical Foot & Ankle Specialist

PATIENT REGISTRATION

Patient Name _____ Date of Birth _____

Social Security Number _____ Age _____

Home Address _____ City _____

State _____ Zip Code _____ Spouse's Name _____

Home Phone Number _____ Mobile Phone Number _____

Email Address _____

May we email you periodic updates on new innovations in podiatric medicine Yes No?

PATIENT SEX: ☐male ☐female **PATIENT IS:** ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Race: ☐American Indian/Alaska Native ☐Asian Black/African American ☐Native Hawaiian/Other Pacific ☐White

Language:_____ **Ethnicity:** ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Not Specified

Do you have medical insurance? Yes No. Are you the: Insured Dependent?

How many Insurances are you covered by? One Two Three Four

Explain Primary and Secondary Insurance(s) _____

In case of emergency whom should we notify? _____

Phone Numbers(s) of person to call in emergency _____

Relation of person to call in Emergency _____

Whom may we thank for referring you to this office? _____

Relationship of person referring you to our office? _____

Employer Information: ☐currently not employed ☐on temporary leave ☐**yes currently employed**

Patient employed by _____
Business Address _____
Patient Business Telephone Number(s) _____
Job Title/Description _____
Spouse employed by _____ Spouse Business Tel. # _____
Spouse Business Address _____

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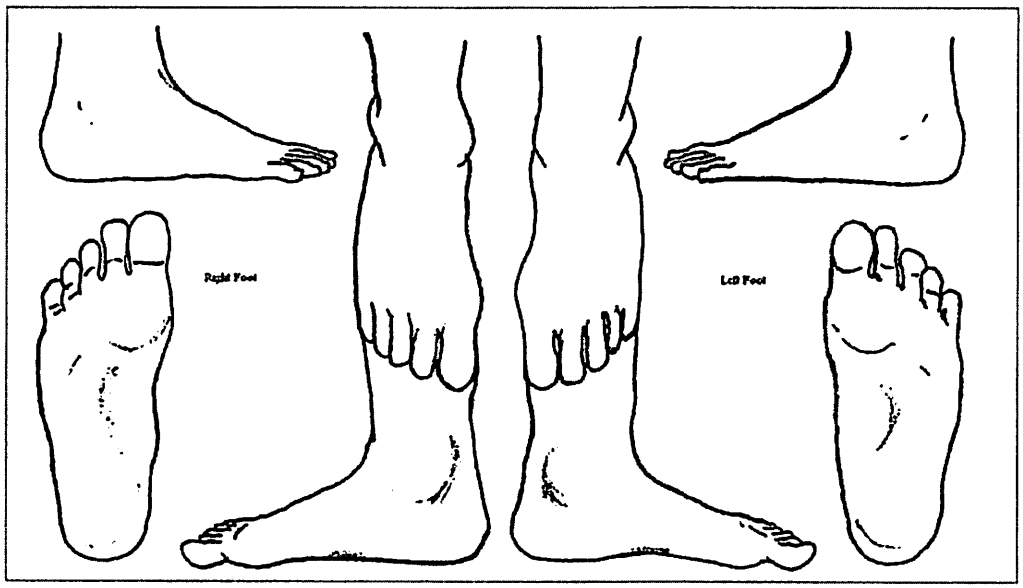
Patient Name: _____ **Date:** _____

HISTORY OF PRESENT ILLNESS (HPI): PLEASE BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

LOCATE the areas of your pain:



When did your problem begin: _____ DAYS _____ MONTHS _____YEARS

ONSET: *GRADUAL* or *SUDDEN*

EXPLAIN: _____

_____

Is the problem getting: □ *WORSE* □ *BETTER* □ SAME

What seems to affect the problem?
When is it better: _____

When is it worse: _____

Have you had this treated before?
□ NOT TREATED
□ ANOTHER DR. TREATED IT **(who when & how):**_____

□ I TREATED IT AT HOME **(how):** _____

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PATIENT HISTORY

Patient Name _____ Date _____

Family Physician

Dr. Name: _____ *Phone:* _____

Address: _____

Primary Hospital Affilation: _____

Any Specialty Physicians being seen:

Name: _____ */Phone:* _____ */ Condition being Treated:* _____

Name: _____ */Phone:* _____ */ Condition being Treated:* _____

Name: _____ */Phone:* _____ */ Condition being Treated:* _____

Please describe the condition(s) that brought you in today:

_____

_____

#1 concern _____ #2 concern _____ #3 concern _____

Is the discomfort (Please circle one):

Burning *Throbbing* *Sharp* *Dull* *Aching* *Other(Describe)* _____

THE *SEVERITY* OF DISCOMFORT/PAIN OF YOUR MAIN PROBLEM *(Please circle one):*

Rating at its worst:

mild **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **unbearable**

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Dear Patient:
For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of our prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmissions of your prescription to mail order pharmacies.

To implement this new program, we need to collection some information from you on your pharmacies of choice. We will define one pharmacy as your MAIN pharmacy; however, you may also provide the information for additional pharmacies to be used as alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) since any information provided will be helpful.

Patient Name: _____ **DOB:**_____

Please list your drug allergies: ☐ No allergies to Medications

_____

_____

Main Pharmacy:

Name (i.e. CVS, Rite-Aid, etc): _____

Street Name and City: _____

Phone: _____ Fax:_____

Additional Pharmacies you would like kept on file:

Name (i.e. CVS, Rite-Aid, etc): _____

Street Name and City: _____

Phone: _____ Fax:_____

Name (i.e. CVS, Rite-Aid, etc): _____

Street Name and City: _____

Phone: _____ Fax:_____

Mail Order Pharmacies:

☐ Medco ☐ CareMark ☐ Express Scripts, Inc. ☐ Wallgreens

Entered in E-scribe Date: _____ **Initials:**_____

Assignment and Release/Financial Responsibility

What is a co-pay?

A co-pay is the small amount you have to pay to access medical care according to your insurance contract. In some cases, it might be $5-$30 but with some insurances, it would be a percentage of your bill (10% is common). This is supposed to provide a slight incentive for you to visit the doctor less and thereby avoid overuse of medical services. Medicare patients don't pay a co-pay "up front", but they are responsible for a small portion of the bill.

What is a deductible?

A deductible is the amount of money that a patient must pay out of pocket before the insurance carrier is responsible for any charges. The average deductible ranges from $100 TO $10,000 and once this has been met the insurance company will begin to pay for covered services. Medicare patients are responsible for a $148 deductible at the beginning of each year.

Why do I have to pay my co-pay and/or deductible?

When you sign up with an insurance carrier, you basically sign a contract which stipulates that you are obligated to pay your copay and/or deductible in certain instances. That usually means that you are required to pay a co-pay and/or deductible for all office visits, including follow-up examinations, outpatient surgical procedures done in our office, etc.

Why do you collect co-pay instead of billing me like my last doctor?

It is much more efficient to collect the co-pay at the time of service. Otherwise it becomes more difficult and expensive to deal with administratively. It needs to be entered in the computer, bills must be mailed, and our billing person will need to track the account for payment, etc. Higher administrative costs in the office ultimately result in higher medical costs for the patient. This policy is not something we can negotiate or change.

Why can't you just "write off" my co-pay and/or deductible?

There are several reasons why this is not a good idea. First, since your insurance "contract" stipulates that you must pay a co-pay and/or deductible, waiving this fee violates your contract. Second, when we sign up with your insurance company, we also sign a contract that says we will collect copays and/or deductible as stipulated in the contract. Third, if the doctor gives you a discount by waiving your co-pay and/or deductible and then bills the insurance company without giving them the same "discount", it could be considered insurance fraud. Thus, many medical billing consultants say that if you waive the co-pay, you cannot bill the insurance company. This rule has effectively eliminated "professional courtesy" which existed when I was a kid. Doctors used to routinely treat each other and their families "for free", but since everyone is insured these days, everyone must pay a copay.

I, the undersigned certify that I (or my dependent) have insurance and assign directly to Great Lakes Foot and Ankle, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible to pay all charges that are not covered by my insurance, including by not limited to, co-pays, deductibles, and non-coved services. I further understand I am responsible for any collection and/or legal fees incurred in the collection of any past due charges. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship	Date

Great Lakes Foot and Ankle Institute
PATIENT SPECIALIST PARTNERSHIP AGREEMENT

Our goal is to provide you with the best care possible. This can happen by using us as your Patient Centered Specialty Care doctor. We work with your Primary Care doctor who is your Patient Centered Medical Home to help you feel better. Below are some important things to remember:

PATIENTS Please:

- After our visit, follow up with your Primary Care doctor as directed.
- Make and keep all appointments with our office and with your Primary Care doctor.
- If you must cancel an appointment, make another one right away.
- Ask questions until you know what you need to do when you leave our office.
- Follow the plan we talked about during your appointment.
- If you are not able to follow the plan for any reason, tell us right away so we can help you set up another plan so you get the best results.

SPECIALIST DOCTOR:

- We will ask you who your Primary Care doctor is. We will let him/her know about your care as soon as possible.
- We will talk with you about your health and what you need to do to take care of yourself.
- We will talk to you by phone and in the office to answer your questions

If your Primary Care doctor tells us that we should continue to take care of a particular condition, the following will also happen:

- We will share information about your plan and goals with your Primary Care doctor as quickly as possible.
- We will give you information; help you to learn how to take care of yourself, and help you to set goals to improve your health.
- We will work with you to set up a plan to help you take care of your health along with your Primary Care doctor.

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*Patient Name*_____ *Date of Birth*_____

*Address of Patient*_____

*City, State Zip*_____

1st Insurance Provider_____
Subscriber Name_____ Date of Birth_____
Employer_____
Insured's ID Number_____
Group Number_____
Insurance Phone Number_____

2nd Insurance Provider_____
Subscriber Name_____ Date of Birth_____
Employer_____
Insured's ID Number_____
Group Number_____
Insurance Phone Number_____

3rd Insurance Provider_____
Subscriber Name_____ Date of Birth_____
Employer_____
Insured's ID Number_____
Group Number_____
Insurance Phone Number_____

If additional insurance information needs to be listed, please feel free to copy this form.
www.greatlakesfootandankle.com

Name_____ Date of Birth_____
Primary Medical Physician_____ PCP phone #_____
What is your present foot or ankle problem?_____
Medications_____

_____

Allergies to Medications_____
List any serious illness or
operations_____

_____

MEDICAL HISTORY: Please check the appropriate box

Edema/Swelling	Yes___No___	Jaundice	Yes___No___
Aids/HIV	Yes___No___	Gout	Yes___No___
Heart problems	Yes___No___	Arthritis	Yes___No___
Thyroid Problems	Yes___No___	High Cholesterol	Yes___No___
Diabetic Type 1___ Type 2___	No___	Hepatitis A__ B__ C__	No___
Heart Attack	Yes___No___	Kidney Problems	Yes___No___
High Blood Pressure	Yes___No___	Anxiety	Yes___No___
Circulation Problems	Yes___No___	Stroke	Yes___No___
Seizures/Epilepsy	Yes___No___	Phlebitis/Blood clots	Yes___No___
Stomach Ulcers	Yes___No___	Pulmonary Disease	Yes___No___
Diabetic Foot Ulcers	Yes___No___	Rheumatic Fever	Yes___No___
Skin Ulcers	Yes___No___	TB	Yes___No___
Venereal Disease	Yes___No___	Varicose Veins	Yes___No___
Alzheimer's/Dementia	Yes___No___	Cancer	Yes___No___
Memory Loss/ Lapses	Yes___No___	Chemotherapy Dates:_____	
Substance Disorders	Yes___No___	Anemia	Yes___No___
Alcohol Disorders	Yes___No___	Neurological Illness	Yes___No___
Asthma	Yes___No___	Heart Murmur	Yes___No___

Family History Of:

Diabetes	Yes___No___
Arthritis	Yes___No___
Stroke	Yes___No___
Hypertension	Yes___No___
Foot problems	Yes___No___
Heart Disease	Yes___No___
Cancer	Yes___No___
Birth Defects	Yes___No___

Tobacco Use:

Previous smoker	Yes___No___
Chews Tobacco	Yes___No___
Smokes Cigarettes	Yes___No___
E-Cigarette	Yes___No___

Alcohol Use:

Never drank alcohol	Yes___No___
Social Drinker	Yes___No___
Heavy alcohol use	Yes___No___

Number of Childbirths:_____
Is there a chance of pregnancy Yes___No__

Marital Status

Married ____
Single ____
Widowed ____
Divorced ____

Drug Use:

Marijuana	Medical Use / Recreational
Cocaine	Yes___No___
IV Drugs	Yes___No___

*Date of last Tetanus: _____

Please list any other medical conditions/surgeries not listed above:

_____

_____

_____

Signature_____ Date_____