SUBURBAN FOOT & ANKLE ASSOCIATES

Phone: 630-226-9860
Fax: 630-312-8662
215 Remington Blvd * Unit A2
Bolingbrook, IL 60440

Patient Name: Sex: ❒ Male ❒ Female

Soc. Sec.#: Date of Birth: Age:

Address: City: State: Zip:

Home Phone: Cell Phone: Email:

Height: Weight: Shoe Size:

Race/Ethnicity: ❒ American Indian/Alaska Native ❒ Asian ❒ Black/African American ❒ White/Caucasian

❒ Hispanic/Latino ❒ More than one race ❒ Native Hawaiian ❒ Pacific Islander ❒ Choose not to report

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Employer: Employer Phone:

Address: City: State: Zip:

Occupation:

In case of emergency contact: Relationship:

Emergency Contact Number(s) That Is Different From Patient:

INSURANCE

Primary Insurance Company:

ID# Group#:

Insured Name: SS# Date of Birth:

Secondary Insurance Company:

ID# Group#:

Insured Name: SS# Date of Birth:

How did you hear of us? ❒ Doctor _____ ❒ Phone Book ❒ Friend ❒ ER

❒ Family ❒ Insurance Website ❒ Hospital ❒ Internet ❒ Other: _____

Primary Care Physician / Specialist Information

Primary Care Physician: Date Last Seen:

Did your primcary care or specialist refer you? ❒ Yes ❒ No

If Yes: ❒ Primary Care ❒ Specialist Dr. _____

Are you currently under the care of any other specialist? ❒ Yes ❒ No

If yes, please list:

I hereby give permission for Dr. Basile to render the proposed Podiatric examination and treatment. I authorize the release of any information to my insurance company and any medical information necessary to process any claim and I request payment of insurance benefits due to Suburban Foot & Ankle Associates to be paid directly to Suburban Foot & Ankle Associates.

I hereby give my permission for Suburban Foot & Ankle Associates to forward any pertinent medical information to my primary or referring physician for continuity of care.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time by either myself or my insurance company in writing.

The above information is true and I will notify Suburban Foot & Ankle Associates of any changes.

Signature: _____ Date: _____

Suburban Foot & Ankle Associates
Patient Clinical Information

Allergies or adverse reactions: ❒ **No Known Drug Allergies**

❒ Aspirin	❒ Iodine	❒ Sulfa	❒ Local Anestetics: _____	❒ Other: _____
❒ Codeine	❒ Novocaine	❒ Tape	❒ Latex	❒ Other: _____
❒ Cortisone	❒ Demerol:	❒ Penicillin		❒ Other: _____

Please indicate any of the following:

❒ Arthritis	❒ COPD	❒ Hypertension	❒ Ulcers	❒ CAD
❒ Asthma	❒ Diabetes	❒ PVD	❒ Stroke	❒ Other: _____
❒ Bleeding Disorders	❒ Heart Disease	❒ SOB	❒ HOH	❒ Other: _____

SURGERIES: List year and reason

MAJOR DISEASE:			**FOOT PROBLEMS:**			**MUSCULO-SKELETAL:**		
Diabetes	❒ Self	❒ Family	Ankle Pain	❒ Self	❒ Family	Arthritis	❒ Self	❒ Family
High Blood Pressure	❒ Self	❒ Family	Bunion	❒ Self	❒ Family	Joint Disease	❒ Self	❒ Family
Angina	❒ Self	❒ Family	Corns / Callouses	❒ Self	❒ Family	Fractures	❒ Self	❒ Family
Heart Disease	❒ Self	❒ Family	Flat Feet	❒ Self	❒ Family	Gout	❒ Self	❒ Family
Heart Attack	❒ Self	❒ Family	Heel Pain	❒ Self	❒ Family	Fibromyalgia	❒ Self	❒ Family
Aids/HIV	❒ Self	❒ Family	Ingrown Toenails	❒ Self	❒ Family	Sciatica	❒ Self	❒ Family
Stroke	❒ Self	❒ Family	Plantar Warts	❒ Self	❒ Family		❒ Self	❒ Family
	❒ Self	❒ Family	Plantar Fasciitis	❒ Self	❒ Family	**HEENT:**		
CARDIOVASCULAR:			Tired Feet	❒ Self	❒ Family	Difficulty Swallowing	❒ Self	❒ Family
Anemia	❒ Self	❒ Family	Other: _____	❒ Self	❒ Family	Eye Problems	❒ Self	❒ Family
Bleeding Disorders	❒ Self	❒ Family				Hearing Problems	❒ Self	❒ Family
Poor Circulation	❒ Self	❒ Family	**NERVOUS:**			Ear Problems	❒ Self	❒ Family
Peripheral Vascular Disease	❒ Self	❒ Family	Numbness	❒ Self	❒ Family		❒ Self	❒ Family
Swelling of feet/Ankle	❒ Self	❒ Family	Headaches	❒ Self	❒ Family	**RESPIRATORY:**		
Phlebitis	❒ Self	❒ Family	Seizure / Convulsion	❒ Self	❒ Family	Asthma	❒ Self	❒ Family
Leg pain when walking	❒ Self	❒ Family	Paralysis	❒ Self	❒ Family	Bronchitis	❒ Self	❒ Family
Anticoagulation Therapy	❒ Self	❒ Family	Loss of Feeling	❒ Self	❒ Family	Lung Disease	❒ Self	❒ Family
			Depression	❒ Self	❒ Family	Tuberculosis	❒ Self	❒ Family
			Anxiety	❒ Self	❒ Family	Ephysema	❒ Self	❒ Family

Please describe the condition for which you are being seen today.

When did this problem begin?

Have you seen a doctor for this? If yes, who:

How have you treated it so far?

Is this condition due to an injury? If so, when?

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis/treatment of my feet/ankles.

Patient / Responsible Party Signature: _____ Date: ____/____/____

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215 Remington Blvd Suite A2 Bolingbrook, IL 60440

MEDICATION LOG

Please include supplements and over the counter medications.

Patient Name: ______________________________ **Date of Birth:**_____/_____/_____

Primary Care Physician: ________________________ **Phone Number:** ________________

Address: __________________________ **City:** ______________ **Zip:** _________

MEDICATION	DOSE / MG	FREQUENCY	CONDITION

Patient Name: _____ Date of birth: ___/___/___

Patient Contract

1. Payment is expected at the time of service. EXCEPTIONS to include: Medicare patients, PPO and HMO members.
2. As a courtesy, we will be happy to bill your primary and secondary insurance companies on your behalf. It is up to each patient to know the rules and limitations of their policies.
3. You are responsible for any portion not covered by your insurance, such as deductible and/or copay. This amount is due at the time of service.
4. If your insurance company does not make the payment you expect, it is up to the policyholder to contact the insurance company. Our office will supply any documentation necessary to expediate the handling of the claim. Please read your explanation of benefits to determine amount owed.
5. Any balance past 60 days is considered delinquent and will be put to patient responsibility.
6. Most insurance companies do not cover supplies given from an office setting; payment will be due at the time of service for such supplies. (ABN SIGNATURE WILL BE REQUIRED) we will attempt to bill these supplies to your insurance company and refund any money received to you. If you need to cancel an appointment, please notify us at least 24 hours in advance. We will gladly reschedule your appointment.
7. A collection fee of 20% will be applied to any outstanding balances that are delinquent over 90 days or submitted to a collection agency.

Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our feed, financial policy or your financial responsibility.
COPAYMENTS: by law we must collect your carrier designated copay at the time of service.
REFERRALS: if plan requires a referral from your PCP it is your responsibility to obtain it prior to your appointment.
NON PLAN PATIENTS: payment is expected at time of service.
MEDICARE: we will submit to Medicare for the entire Medicare allowed amount. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed directly to secondary insurance if you have one.

We accept CASH, CHECK, MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS

I have read and understood the above Patient Contract and Financial Policy for Suburban Foot & Ankle Associates.

Signature of patient, parent or legal guardian: _____ Date: ___/___/___

Acknowledgment of receipt of Notice of Privacy Practice

*I acknowledge that I was provided a copy of the Notice of Privacy Practices from Suburban Foot & Ankle Associates and that I have read (or had the opportunity to ask for a copy, if I so choose) and understand the Notice.
Signature of patient, parent or legal guardian: _____ Date: ___/___/___

Request for Confidential Communications

*I request that all confidential communications to me from Dr. Basile, Suburban Foot & Ankle Associates and staff be handled in the following manner: ❒ **RELEASE MEDICAL & BILLING INFORMATION TO ONLY MYSELF**

Name and Phone Number	This person's relation to you	Information we can share (check box)
		❒ Billing Information ❒ Appointment information ❒ Medical Information
		❒ Billing Information ❒ Appointment information ❒ Medical Information

Credit Card Authorization Form

By signing below, I am hereby authorizing Suburban Foot & Ankle Associates to charge my credit/debit card for any account balances put to my responsibility as outlined in my insurance policy & benefits. This payment will be deducted on the 15th of every month.

Card Type: ( )Visa ( )Mastercard ( )Discover ( )American Express

Card Number: _____

Expiration Date: _____/_____/_____ Security Code: _____

Cardholders Name: _____

Cardholders Address: _____

City: _____State: _____Zip Code: _____

Telephone Number: _____

_____ _____

Cardholders signature Date

_____

Office Personnel:

Patient Name: _____

SFAA account number: _____