

Instep Podiatry, P.C.
Foot and ankle specialists and surgeons
200 East Willow Avenue * Wheaton, Illinois 60187

REGISTRATION
(PLEASE PRINT)

Date _____ Home Phone _____
Cell Phone _____
Email Address _____

Patient _____
Last Name First Name Initial

Responsible Party (if a minor) _____
Street Address _____
City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed By _____
Business Address _____
Occupation _____ Business Phone _____

Spouse (or responsible party) Name _____ Birthdate _____
Business Name and Address _____
Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____
Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? No Yes If yes,
Name of Primary Insurer _____
Contract # _____ Group # _____ Subscriber # _____
Name of Secondary Insurer (if any) _____
Contract # _____ Group # _____ Subscriber # _____

In case of emergency, who should be notified? _____ Phone _____
How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____
For any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature Date

INSTEP PODIATRY, P.C.

NAME: _____ DATE OF APPOINTMENT: _____

REASON FOR SEEING THE DOCTOR? _____

ANY OTHER PAIN? YES _ NO _ WHERE? _____

WAS THIS AN ACCIDENT? YES _ NO _ DATE OF INJURY? _____ HOW DID INJURY OCCUR? _____

HAVE YOU HAD PREVIOUS TREATMENT FOR FOOT OR ANKLE PROBLEMS? _____

DO YOU HAVE OR ARE YOU BEIND TREATED				ARE YOU ALLERGIC							
FOR:				TO:							
PLEASE ANSWER EACH QUESTION											
	YES	NO		YES	NO		YES	NO			
DIABETES	___	___	ASTHMA	___	___	PENICILLIN	___	___	LOCAL ANESTHIA	___	___
HIGH BLOOD PRESSURE	___	___	ANEMIA	___	___	ASPIRIN	___	___	IODINE	___	___
HEART DISEASE	___	___	STOMACH DISORDER	___	___	CODEINE	___	___	SULFA DRUGS	___	___
ARTHRITIS	___	___	INTESTINAL DISORDER	___	___	ADHESIVE TAPE	___	___	OTHER	_____	_____
DRUG REACTION	___	___									

NAME AND ADDRESS OF FAMILY PHYSICIAN _____

LAST DATE YOU SAW FAMILY PHYSICIAN _____

ANY ILLNESSES IN LAST 5 YEARS? YES _ NO _ PLEASE LIST ALL _____

LIST ALL MEDICATIONS YOU ARE TAKING _____

SIGNATURE _____ DATE _____