Lake shore Foot and Ankle P. C.

Last Name ______________________________ Date _______________________________

First Name____

Preferred Name____

Middle name, suffix____

Former Last Name____

Sex_________ DOB _______________

Address____

City _______________________State ______________ Zip Code_____________________

Home phone_____________________________ Mobile phone______________________

Consent to text YES___________ NO___________

Patient email____

Language_______________________________ Marital status______________________

Race__________________________________ Ethnicity___________________________

Occupation____

How did you hear about us? Google__ZocDoc__Doctor's Referral ___Insurance__Family/Friend__

What is your Insurance ____

Do you have secondary Insurance? ____

Name of Primary Care Physician____________________ Last seen ________________

Name and address of Pharmacy____

What is the reason for today's Visit ____________________________right or left

____

Allergies____
____

NKDA

____

Medication **Dose** **How taken**

____
____
____

HT _________ Weight ________ Shoe size__________

Family History

List Health Problems or Disabilities. Relationship Alive or age of Death

____________________________ __________ __________

____________________________ __________ __________

____________________________ __________ __________

Any complications with anesthesia? _________________________

Do you have Pets? Cats_______ Dogs__________

Social History

Smoking status- Never Former- (How many times a week) Everyday Some days

____

Tobacco Smoking Status- Never Former-(How many times a week) Everyday Some days

____

Alcohol intake- Never Former- (How many times a week) Everyday Some days

____

Illicit drug- Never Former Everyday Some days **(circle one)**

Has smoked since age ___________________________________

Tobacco-years of use _____________________________________

E-cigarette/vape status: Never Former Current **(circle one)**

Surgical History Date

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Past History Please check off current or past problems

- ❏ Arthritis
- ❏ Anemia
- ❏ Artificial Joints
- ❏ Asthma
- ❏ Back Pain
- ❏ Bleeding Disorder
- ❏ Blood Clot
- ❏ Bruise easy
- ❏ Cancer
- ❏ Coronary artery Disease
- ❏ Deep vein Thrombosis
- ❏ Diabetes
- ❏ Dialysis
- ❏ Dyslipidemia
- ❏ Edema
- ❏ Fibromyalgia
- ❏ Foot Deformity
- ❏ Frostbite
- ❏ Gout
- ❏ Heart Disease
- ❏ Hepatitis
- ❏ Hernia
- ❏ Hypertension
- ❏ Kidney disease
- ❏ Leg or foot ulcers
- ❏ Liver disease
- ❏ Lung disease
- ❏ Nerve damage
- ❏ Neuroma
- ❏ Organ transplant
- ❏ Osteoporosis
- ❏ Pacemaker
- ❏ Peripheral vascular disease
- ❏ Polio
- ❏ Pulmonary embolism
- ❏ Raynaud's disease
- ❏ Rheumatoid arthritis
- ❏ seizure/ epilepsy
- ❏ Stroke
- ❏ Substance abuse
- ❏ Tuberculosis
- ❏ Thyroid problems
- ❏ Varicose veins
- ❏ Wounds
- ❏ Neuropathy
- ❏ HIV/AIDS
- ❏ Headaches

Any other problems not listed:

____

____

____

____

LAKESHORE FOOT AND ANKLE P.C

806 N Central Ave Suite 103
Highland Park, IL 60035
(847) 432-6400 (PH)
(773) 871-1244 (FX)

2623 N Halsted
Chicago, IL 60614
(773)477-3668 (PH)
(773) 871-1244 (FX)

Dear Patient,
If you are unable to keep a future appointment, we ask that you give our office a call at least 24 hours prior to your appointment time.
Canceling the appointment in advance allows another patient the opportunity to be seen at that time.

If you do not keep your appointment without canceling, we will administer a NO SHOW FEE. We understand that some appointments cannot be kept, but we ask that you please call us in advance and let us know.
If you miss your appointment without calling to cancel or reschedule, you will be charged $50. We will not bill this to your insurance company. This will be your financial responsibility.
We appreciate your consideration by letting another patient use your appointment time, if you can't make it.
Thank you,
Dr.Stein

I authorize Lake Shore Foot and Ankle P.C to release my medical records to my spouse, members of my family and/or legal personal representative as indicated below. I understand the person(s) named on this authorization will be given access to obtain or review my records and have my permission to discuss my care or obtain results/information on my behalf. This authorization extends only to the person(s) I have identified below.

Name	Relationship	Phone Number	Birthdate

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FINANCIAL POLICY

I agree to personally pay for all non-covered services, plus all required deductibles and copayments due to Lake Shore Foot and Ankle for and covered services. I understand that I am financially responsible for all changes whether or not paid by my insurance.

If you are **not** covered by your insurance plan, you must pay in **full** at the time of service.

Lake Shore Foot & Ankle PC participates in many insurance plans. A list of the plans we accept are available on our website (www.myachingfoot.com)

To set up a payment plan with the office, you must contact the office. (773) 477-3668 Or set up a payment plan the day of your appointment.

For continuity of care with our practice, we require that you must maintain a valid credit card in our compliant secure database. We understand your concerns with providing us this confidential information but assure you that this information is kept confidential.

I hereby acknowledge receipt of the services, authorize Lake Shore foot & Ankle PC to bill the credit card I have provided above to keep on file for any services, and agree to take all further actions required to pay the charges in full and perform the obligations set forth in my agreement with my credit card issuer.

Check only one option

- ❏ **Option 1**: I will receive two statements from lake shore foot & ankle. If no payment is received, the credit card information below will be processed for my balance on my account 15 days following my second statement and an email receipt will be sent to me.
- ❏ **Option 2**: I will leave $_____._____ via Cash or Credit Card deposit per visit. I will be billed for any remaining balance or refunded if I overpay on my account.
- ❏ **Option 3**: I am a Self-Pay patient and will pay full balance at the time of the services.

I have read, understood and agree to this policy. (Parent or guardian complete if patient is a minor)

Credit Card #:________________________________ EXP: ___________ CVV:_________

Sign Name:____Date:___________________