

Podiatry & Sports Center, Ltd.

Dr. David W. O'Brian

10 N. Roselle Road Suite 300 Roselle, Illinois 60172 (630) 529-6634

www.runningsportsdoc.com

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone() _____ Work Phone() _____ Cell Phone() _____

E-Mail Address _____ Marital Status _____

Date of Birth _____ Age _____ Social Security Number _____

Occupation _____ Employer _____

How Did You Hear About Our Office? _____

If Minor Name of Legal Guardian _____ Address _____

Home Phone() _____ Work Phone() _____ Cell Phone() _____

INSURANCE INFORMATION

Primary Insurance _____ Insured Name _____

Insured ID No. _____ Policy Group No. _____ Insured Date Of Birth _____

Patient's Relation to Insured: Self ___ Spouse ___ Child ___ Other _____

Insurance Type: PPO ___ EPO ___ HMO ___ Medicare ___ Self-Pay ___ Other _____

Is There A Family Member Or Other Person Such As A Coach, Trainer Or Instructor You Would Like For Us To Share Your Medical Information?

___ Yes Name _____

___ No

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS:

Name	Dose	How Often Do You Take?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL PRIOR SURGERIES

Type Of Surgery	Date	Type Of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS OTHER THAN FOR SURGERY:

Reason For Hospitalization	Date	Reason For Hospitalization	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Marital Status: ___Single ___Married ___Partnered ___Separated ___Divorced ___Widowed

Alcohol Use: ___Never ___Social ___Daily ___History Of Alcohol Abuse

Tobacco Use: ___Never ___Quit-How Long Ago_____ ___Smoke___Packs/Day For ___Years

Exercise: ___Never ___Occasional ___Several Times Per Week ___Daily

Type Of Exercise Or Activity _____

Family History

Have Either of Your Parents Or Brothers Or Sisters Had Any Of The Following: ___Diabetes ___Cancer

___Heart Disease ___High Blood Pressure ___Stroke ___Coronary Artery Disease

___Thyroid Disease ___Rheumatoid Arthritis ___Other_____

Your Medical History

Allergies: ___None Known ___Medications:_____

___Tape ___Latex ___Shellfish ___Iodine ___Other_____

Have You Ever Had Any Of The Following

Acid Reflux	Y	N	High Blood Pressure	Y	N
Anemia	Y	N	Kidney Disease	Y	N
Arthritis	Y	N	Liver Disease	Y	N
Asthma	Y	N	Low Blood Pressure	Y	N
Back Trouble	Y	N	Migraine Headaches	Y	N
Bladder Infections	Y	N	Mitral Valve Prolapse	Y	N
Abnormal Bleeding	Y	N	Neuropathy	Y	N
Blood Clots	Y	N	Open Sores	Y	N
Blood Transfusions	Y	N	Pneumonia	Y	N
Bronchitis/Emphysema	Y	N	Polio	Y	N
Cancer	Y	N	Rheumatic Fever	Y	N
Diabetes	Y	N	Sickle Cell Disease	Y	N
Fibromyalgia	Y	N	Skin Disorder	Y	N
Gout	Y	N	Sleep Apnea	Y	N
Heart Attack	Y	N	Stomach Ulcers	Y	N
Heart Disease/Failure	Y	N	Stroke	Y	N
Hepatitis	Y	N	Thyroid Disease	Y	N
HIV+/AIDS	Y	N	Tuberculosis	Y	N

Other Conditions: _____

Current Problem

What Specific Problem Brings You To The Office Today? _____

Where Is The Pain/Problem Located? _____

How Long Ago Did The Problem First Start? _____ Days/Weeks/Months/Years

Did Your Pain/Problem _____ Begin Suddenly _____ Gradually Develop Over Time

How Would You Describe Your Pain ___ No Pain ___ Sharp ___ Dull ___ Aching ___ Burning
 ___ Radiating ___ Stabbing ___ Itching ___ Other _____

How Would You Rate Your Pain On A Scale From 0 To 10? (Please Circle)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Since The Time Your Problem Began Has It ___ Stayed The Same ___ Become Worse ___ Improved

What Makes Your Pain Feel Worse? ___ Walking ___ Standing ___ Running ___ Daily Activities ___ Resting
 ___ Dress Shoes ___ High Heels ___ Flat Shoes ___ Closed Toed Shoes ___ Other _____

What Makes Your Pain Feel Better? _____

What Treatments Have You Had For This Problem? _____

For This Problem Have You Had ___ Tests ___ Xrays ___ MRI ___ Bone Scan ___ Diagnostic Ultrasound
Was This Problem Caused By An Injury? ___ Yes (Describe) _____
___ No

If Yes Was It A Work Related Injury? ___ Yes ___ No

I Hereby Give My Permission To Dr. David O'Brian, His Assistants And Associates To Administer Treatment And Perform Such Procedures As May Be Deemed Necessary In The Diagnosis And/Or Treatment Of My Condition.

I Acknowledge That I Was Provided A Copy Of The Notice Of Privacy Practices (HIPAA Notice), And I Have Read, Or Have Had The Opportunity To Read, And Understand The Notice.

I Authorize Podiatry & Sports Center, Ltd. And Associates To Use Photography, Film Or Videotape For Medical Records Purposes. In Addition, I Understand These Materials May Be Used For Teaching Purposes Which May Include Medical Lectures, Patient Education, And Website Education. I Am Aware My Name And Identity Will Not Be Disclosed For Privacy Purposes.

To The Best Of My Knowledge, I Have Answered The Questions On This Form Accurately. I Understand That Providing Incorrect Information Can Be Dangerous To My Health. I Understand That It Is My Responsibility To Inform The Doctor And Office Staff Of Any Changes In My Medical Status.

Signature Of Patient, Parent Or Guardian

Date

**Podiatry & Sports Center, Ltd.
Financial Policy**

Thank you for choosing Podiatry & Sports Center Ltd. as your health care provider. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Should you have any questions regarding any aspect of your financial status with our office please feel free to contact our Office Manager at 630-529-6634.

Self-Pay-Payment is required at the time of the visit unless prior arrangements have been made. We accept Visa, MasterCard, Discover, American Express as well as cash and personal check.

Insurance PPO-We are providers for some but not all insurance plans. You are responsible for verifying that we are providers for your plan. In this case we will bill your insurer directly and you will be responsible for paying your co-payment, co-insurance and deductibles. All co-payments are due at the time of service. You must present your insurance card or full payment will be due at the time of service.

HMO-If you are an HMO member you must have the necessary referrals at the time of the visit or your plan requires that we reschedule your visit.

Medicare-We accept Medicare assignment for medical services approved by Medicare. We will bill Medicare directly for those services and you will be responsible for paying your co-insurance and deductibles. There are services and supplies considered necessary by the doctor for you treatment that are not covered by Medicare and payment for these charges is due at the time of service.

Non-Covered Services-We are committed to provide the best possible treatment for our patients. We provide services that are determined by medical practice to be medically necessary. Not all insurers cover all medical services. This will serve as notice that you are responsible for payment of those services considered necessary by your doctor regardless of any insurance company's arbitrary determinations of what it considers non-covered as medically unnecessary or experimental.

Easy Pay Consent Form-We require all patients for whom we bill insurance in lieu of payment to sign an Easy Pay Consent form. This is a credit card voucher kept on file and used for payment of all co-insurance and deductible amounts as well as any other unpaid balances.

Appointment Cancellation Policy-A \$75.00 charge will be assessed for missed appointments and appointments cancelled with less than 24 hours' notice. Monday appointments must be cancelled on the preceding Friday. This assessment will apply for therapy appointments as well as doctor's appointments. The charge will not be billed to insurance.

Past Due Accounts-All payments are due within 30 days of the statement date. Past due accounts are subject to collection proceedings and are subject, but not limited to, collection fees, attorney's fees and court fees in addition to the balance due.

I understand the Financial Policy as presented above. I understand that I am responsible for payment of all services. If payment is not received from the insurance carrier or other responsible party in 90 days I will be billed directly.

Name of Patient (please print)

Signature of Patient or Responsible Party

Date