American Surgeons Group

Primary Care Physician _____ **Today's Date** _____

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____ Gender M/F

Birthdate ____/____/____ Marital Status S / M / W / D

Street Address _____ City _____ State _____ Zip _____

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

Email _____ Height _____ Weight _____ Shoe Size _____

Pharmacy _____

What is your FOOT or ANKLE problem? _____ How Long? _____ How much pain? (0-10) ____/10

What Type of Symptoms: Sharp? Shooting? Burning? Achy? Tingling/Numb? Difficult to walk?

What Relives Your Symptoms? _____ Do You Have: Nausea? Fever? Chills?

What Type of Treatments Are You Expecting? _____ What Other Treatments Have Been Tried? _____

EMPLOYER INFORMATION

☐ Retired Employer _____ Work Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Phone ( ) _____ Relationship _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Grp#: _____

Subscriber Name: _____ Relationship: _____

Subscriber Date of Birth: _____ Sex: _____

Employer Name: _____ Phone#: _____

Address: _____

Secondary Insurance: _____ ID#: _____ Grp#: _____

Subscriber Name: _____ Relationship: _____

Subscriber Date of Birth: _____ Sex: _____

Employer Name: _____ Phone#: _____

Address: _____

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SUMMARY SHEET — PATIENT AT A GLANCE

Patient Name: _____ Male/Female Birth Date: _____

Address: _____ Phone No.: _____

If appropriate, Name & Phone No. of Legally Responsible Person: _____

Special considerations due to cultural or religious beliefs: □ Yes □ No
Specify: _____

Language: □ English □ Spanish □ Other: _____ □ Translator needed

Limitations: □ none □ hearing □ vision □ cognitive impairment □ Mobility □ illiterate
Ready to learn: □ Yes □ No
Learning preference: □ written □ verbal □ demonstration □ Other: _____

Personal History: □ Smoking_____pks/day □ Alcohol ____/day/week
□ Recreational Drug Use/Abuse □ Advanced Directive Initiated

ALLERGIES

□ No Known □ Penicillin □ Sulfa □ Codeine □ Latex □ Aspirin □ Food
□ Other: _____

Previous reactions to anesthesia □ None □ Other: _____

MEDICAL DIAGNOSIS & CONDITIONS

□ No Known □ Asthma □ Diabetes □ Hypertension □ Anemia □ Arthritis □ Back □ Bowel □ Cancer □ Circulation □ Heart Attack □ Hepatitis □ Kidney/bladder □ Seizure □ Stomach □ Stroke □ Thyroid □ Other: _____

Date	SIGNIFICANT SURGICAL AND INVASIVE PROCEDURES

EXCHANGE OF MEDICAL INFORMATION

All requests by patients must be signed and in writing by letter, fax, or medical release of information form. Verbal requests are not acceptable. A request is not necessary if the information is shared with a physician we have referred to you.

PAPERWORK TO FILLED OUT BY DOCTOR

An appointment may be required to have forms completed. Please check with the office to see if your form will require an office visit. If a scheduled appointment is required, any copay is due at time of visit.

COPYING FEES

We do charge a fee for copying medical records. The fee and length of time to copy is dictated by the information requested. Copying fee is due at the time of pick up. A fee does not apply if information is being sent to another physicians office. Xrays cannot be copied. However, they may be borrowed to take to another physicians office. There is a $100 deposit required, check or credit card, that will be returned once the xrays are received back in our office.

DIAGNOSIS CODES

Our office cannot recode an office visit because your insurance does not cover certain procedures. This is illegal and considered fraud. It is the patients responsibility to know what your insurance plan covers. Orthotics and some durable medical equipment, and physical therapy may not be covered by your plan. Always call your insurance company to verify coverage. It will be your responsibility to pay any unpaid amount after your insurance does not cover within 30 days.

TEST RESULTS

Our office will maintain your test results ,you will be scheduled for a follow -up appointment. At the follow up appointment the results will be reviewed with you by the doctor. If another physician ordered the test and copies are sent to us, it is the responsibility of the ordering physician to contact you.

Acknowledgement of receipt of notice of Privacy practices. Version Effective April 13, 2004.

_____

Signature

I acknowledge and understand the office policies and procedures.

Signature: _____

Date: _____

American Surgeons Group
1757 Ridge Road, Homewood
19638 LaGrange Rd, Mokena
3042 Chicago Rd, South Chicago Hts
P: 708-799-7500
F: 815-215-1144
www.asgfoot.com

American Surgeons Group

AUTHORIZATIONS

I consent to the medical services provided by American Surgeons Group and its employees and designees as deemed necessary.
I permit American Surgeons Group to release my medical information for the purpose of carrying out treatment, payment or health care operations.
I authorize payments of my medical benefits to American Surgeons Group
I acknowledge having received, read, and understand the information in the Financial Policy and agree to abide by the terms set forth in this document. I understand I am financially responsible for all co-payments, deductibles, co-insurance and non-covered services as determined by my insurance plan.
If the account is not paid in full, it will be sent to collection.

I understand all of the above and hereby state that the information I provided on all pages is accurate and correct to the best of my knowledge.

Print Name

Relationship to patient if not patient

Signature

Today's Date

American Surgeons Group

MEDICATIONS LIST

Patient Name: _____ Birth Date: _____

In an emergency, contact: _____ Phone No. _____

At each visit, verify patient prescriptions medications, over-the-counter drugs, herbals and vitamins. If patient is no longer taking the medication, cross it off the list. When adding new medication(s), fill in the appropriate columns. Make a copy and give to the patient.

Date	Medications, Over-the-Counter Drugs, Herbals and Vitamins	Strength	Dose	Frequency

Disclaimer: This list is provided to you by this facility as an educational tool. We have noted all the medications you are currently taking, including the medication we have prescribed. This list is prepared based on the information you have provided to us. This facility is not responsible to maintain, prescribe or refill any of the above medications.