GREAT LAKES FOOT & ANKLE CENTERS

6123 Green Bay Road, Suite 100
Kenosha, WI 53142

5802 Washington Ave, Suite 202
Racine, WI 53406

Patient Information (Please use full legal name, no nicknames please)
Last Name: First Name: Middle Name:
Date of Birth: SSN: Gender: □ Male □ Female
Address: City: State:
Zip Code: Height : Weight : Shoe Size :
Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )
Preferred Phone: □ Home □ Cell □ Work Email:
Race/Ethnicity: □ American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic/Latino
□ More Than One Race □ Native Hawaiian □ Pacific Islander □ White/Caucasian □ Choose Not To Report
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Student: □ Yes □ No ***If Yes***: □ Full Time □ Part Time
Employer:
Address: City: State: Zip:
Emergency Contact Name: Relationship:
Emergency Contact Phone: ( )
***If <u>Minor</u> Patient Only: (Please use full legal name, no nicknames please)**
Person Responsible for Bill: □ Mother □ Father □ Other:
Mother's First & Last Name: DOB: SSN:
Father's First & Last Name: DOB: SSN:
Address (if different from above):
Parents' Marital Status: □ Single □ Married □ Separated □ Divorced
<u>IMPORTANT</u> : IF PARENTS ARE SEPARATED OR DIVORCED, WE REQUIRE WRITTEN PARENTAL CONSENT FROM BOTH PARENTS <u>BEFORE</u> WE ARE ABLE TO TREAT THE CHILD.
Insurance Information (Please allow receptionist to photocopy your insurance ID cards)
Primary Insurance Name: Member ID: Group #:
Policy Holder's Name: Policy Holder's DOB: Policy Holder's SSN:
Insurance Claims Address & Phone:
Secondary Insurance Name: Member ID: Group #:
Policy Holder's Name: Policy Holder's DOB: Policy Holder's SSN:
Insurance Claims Address & Phone:
How Did You Hear About Our Office?
□ Friend □ Family □ ER □ Insurance Company □ Hospital □ Internet □ Doctor :

Prior Medical History Information

Allergies or Adverse Reactions: ☐ **No Known Drug Allergies**

☐ Aspirin ☐ Codeine ☐ Cortisone ☐ Iodine/Shellfish ☐ Novocain ☐ Demerol ☐ Sulfa ☐ Tape ☐ Penicillin ☐ Latex ☐ Other, please list:

Major Disease:		***Cardiovascular:***		***Foot Problems:***	
Cancer	□ Self □ Family	Anemia	□ Self □ Family	Ankle Pain	□ Self □ Family
Diabetes	□ Self □ Family	Bleeding Disorder	□ Self □ Family	Bunion	□ Self □ Family
H/L Blood Pressure	□ Self □ Family	Peripheral Vascular Disease	□ Self □ Family	Corns/Callouses	□ Self □ Family
Angina	□ Self □ Family	Poor Circulation	□ Self □ Family	Flat Feet	□ Self □ Family
Heart Disease	□ Self □ Family	Phlebitis	□ Self □ Family	Heel Pain	□ Self □ Family
Heart Attack	□ Self □ Family	Anticoagulation Therapy	□ Self □ Family	Ingrown Toenail	□ Self □ Family
Aids/HIV	□ Self □ Family	DVT/Blood Clots	□ Self □ Family	Plantar Warts	□ Self □ Family
Stroke	□ Self □ Family	Other:	□ Self □ Family	Plantar Fasciitis	□ Self □ Family
Other:	□ Self □ Family	***Musculoskeletal:***		Athlete's Foot	□ Self □ Family
Nervous:		Arthritis	□ Self □ Family	Tired Feet	□ Self □ Family
Numbness	□ Self □ Family	Joint Disease	□ Self □ Family	Other:	□ Self □ Family
Headaches	□ Self □ Family	Gout	□ Self □ Family	***Respiratory:***	
Seizure / Convulsion	□ Self □ Family	Fibromyalgia	□ Self □ Family	Asthma	□ Self □ Family
Paralysis	□ Self □ Family	Sciatica	□ Self □ Family	Bronchitis	□ Self □ Family
Loss of Feeling	□ Self □ Family	Other:	□ Self □ Family	COPD	□ Self □ Family
Depression	□ Self □ Family	***HEENT:***		Emphysema	□ Self □ Family
Anxiety	□ Self □ Family	Hearing Problems	□ Self □ Family	Short of Breath	□ Self □ Family
Aneurysm	□ Self □ Family	Eye Problems	□ Self □ Family	Lung Disease	□ Self □ Family
Autism	□ Self □ Family	Ear Problems	□ Self □ Family	Tuberculosis	□ Self □ Family
Other:	□ Self □ Family	Other:	□ Self □ Family	Other:	□ Self □ Family

Surgeries **(List Procedure and Year)**:

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?

Primary Care Physician/Other Specialist Information

Primary Care Physician Name: Date Last Seen:

Primary Care Physician Address: Phone: ( )

Did your Primary Care Physician or Other Specialist Refer You? ☐ Yes ☐ No

Are You Currently Under the Care of Any Other Specialists? ☐ Yes ☐ No

If Yes, Please List:

I certify that the above information is true and correct to the best of my knowledge. I hereby give permission for Great Lakes Foot & Ankle Centers to administer and perform such procedures as may be deemed necessary in diagnosis/treatment of my feet/ankles. 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 Great Lakes Foot & Ankle Centers to be paid directly to Great Lakes Foot & Ankle Clinics.

I hereby give my permission for Great Lakes Foot & Ankle Centers 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 me, or my insurance company, in writing. **I will notify Great Lakes Foot & Ankle Clinics of any changes.**

Signature: **Date:**

Medication Log (Please include supplements and over the counter medications)

Patient Name:

Medication	Dose/MG	Frequency	Condition	Prescriber

Patient Contract

Payment is expected at time of service. EXCEPTIONS to include: Medicare patients, PPO and HMO/POS members.
As a courtesy, we will be happy to bill your primary and secondary insurance company on your behalf. It is up to each patient to know the rules and limitations of your policies.
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.
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 expedite the handling of the claim.
Any balance past 90 days in considered delinquent, and will be put to patient responsibility. It is your responsibility to contact your insurance company if payment is delayed.
Most insurance companies **DO NOT COVER SUPPLIES** given in an office setting; payment will be due at the time of service for such supplies (**ABN SIGNAUTURE 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.

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 fees, financial policy, or your financial responsibility.

COPAYMENTS: by law we must collect your carrier designated copay at the time of service.

REFERRALS: if your insurance policy requires a referral from your PCP, it is your responsibility to obtain it prior to your appointment. If you do not obtain a referral, you will be responsible for all charges.

SELF PAY PATIENTS: Payment is REQUIRED at the 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% co-insurance, which will be billed directly to secondary insurance if applicable.

WE ACCEPT CASH, CHECK, MASTERCARD, VISA, DISCOVER, and AMERICAN EXPRESS.

Request for Confidential Communications

I request that all confidential communication to me from Dr. Bostanche / Dr. Basile and staff at Great Lakes Foot & Ankle Centers be handled in the following manner: **Check all that apply.**

Written Communication (Appointments/Medical Records/Billing/Insurance Information):

- □ to my home address
- □ to a different address: _____
- □ to my email address: _____

Telephone Communication (Appointments/Medical Records/Billing/Insurance Information):

- □ Home number
- □ Cell phone
- □ Different number : _____
- □ With family member(s): _____
- □ Answering machine/voicemail

Test Results:

- □ May only release test results to myself
- □ May leave voicemail, inform spouse, or other family member(s): _____

Acknowledgement of Receipt of Notice of Privacy Practice

I acknowledge that I was offered/provided a copy of the Notice of Privacy Practices from Great Lakes Foot & Ankle Centers and that I have read (or had the opportunity if I so chose) and understand the notice.

I have read & understand the above Patient Contract & Financial Policy/Confidential Communications for Great Lakes Foot & Ankle Centers

Signature of Patient, Parent, or Legal Guardian: _____Date: _____