



Reviewed by: _____ ☐ Scanned

THANK YOU SO MUCH FOR JOINING US

Today's Date: _____

PATIENT NAME: _____
(Last) (First) (Middle)

DATE OF BIRTH: ____/____/____

SEX: ☐ Male ☐ Female

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

S.S#: ____ - ____ - ____
(please provide **at least** the last 4 of S.S)

ADDRESS: _____
(Street) (City) (State) (Zip)

PHONE: _____/_____
(Home) (Cell)

E-MAIL ADDRESS: _____

APPOINTMENT REMINDERS IN FORM OF : TEXT / EMAIL / BOTH

OCCUPATION: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Child

EMERGENCY CONTACT: _____/_____/_____
(Name) (Phone) (Relationship)

HOW DID YOU HEAR ABOUT US?:

☐ DR. _____ ☐ FAMILY _____

☐ OTHER: _____ ☐ FRIEND _____

PRIMARY INSURANCE: _____

ID NUMBER/ SUBSCRIBER ID NUMBER: _____

GROUP NUMBER: _____

POLICY HOLDER'S NAME: _____

POLICY HOLDER'S DATE OF BIRTH: _____
(If not self)

RELATIONSHIP: ☐ Self ☐ Spouse ☐ Parent ☐ Other

ADDITIONAL INSURANCE: _____

POLICY HOLDER'S NAME: _____

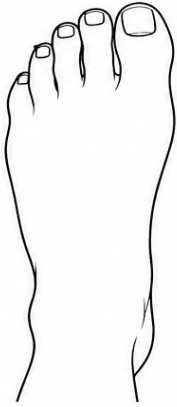
POLICY HOLDER'S DATE OF BIRTH: _____

ID NUMBER/ SUBSCRIBER ID NUMBER: _____

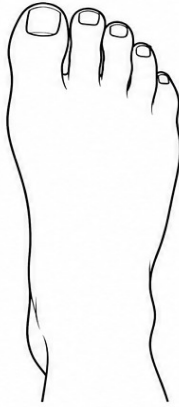
GROUP NUMBER: _____

PATIENT'S NAME (PRINT): _____

PLEASE INDICATE AREA(S) OF PAIN WITH Xs OR CIRCLE AREA (S):



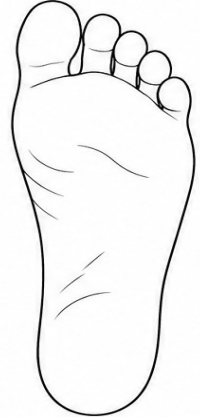
LEFT FOOT



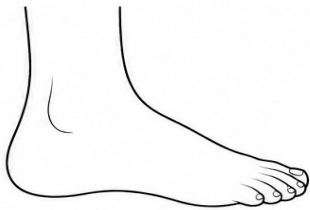
RIGHT FOOT



LEFT FOOT



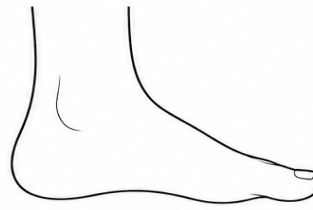
RIGHT FOOT



LEFT FOOT



RIGHT FOOT



LEFT FOOT



RIGHT FOOT

WHAT IS THE REASON FOR YOUR APPOINTMENT?:

PREVIOUS PODIATRIC TREATMENTS

☐ Foot/ Ankle Surgery ☐ Orthotics ☐ Oral Medications ☐ Cortisone Shots ☐ Physical Therapy

Please describe:

PHARMACY

Name: _____ Address: _____

City, State, Zip: _____ Phone number: _____

Primary Care Physician Information:

Medical Doctor's Name: _____ DATE LAST SEEN: _____ Phone #: _____

PATIENT'S NAME (PRINT) : _____

MEDICAL HISTORY

Shoe Size: _____ Height: _____ Weight: _____

Medications: (Please list current medications that you are taking. Prescription and over the counter)

Drug Allergies: Penicillin/ Sulfa/ Codeine / NSAIDs / Local Anesthetic/ Latex / Tape / Iodine/ NONE

OTHER: _____ INITIALS

Indicate which of the following you have had or presently had. ****CHECK YES OR NO TO **EACH ITEM.****

Arthritis / Rheumatism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial joints (Hip, Knee, etc.)	☐ Yes	☐ No	H. I. V Positive	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Diabetes If yes, please complete the *** section	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Motion Sickness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Neurological Disorder (Parkinson's / Stroke)	☐ Yes	☐ No
Heart Problems (Surgery, Disease, Attack)	☐ Yes	☐ No	Psychiatric/ Psychological Care	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Stomach Problems / Acid Reflux	☐ Yes	☐ No
Hepatitis A / Infectious B (serum)	☐ Yes	☐ No	Cancer (lung, breast, colon, prostate, skin, ovarian)	☐ Yes	☐ No
Hepatitis C	☐ Yes	☐ No	Ulcers (Diabetic)	☐ Yes	☐ No

Are you currently pregnant? ☐ Yes ☐ No Estimated Due Date: _____

Do you drink ALCOHOL? ☐ Yes ☐ No (☐ Beer ☐ Wine ☐ Hard Liquor) Drinks per week: _____

Do you smoke ☐ Yes ☐ No (☐ Cigarettes ☐ Vape ☐ Chewing tobacco) Use per day: _____

***If you are DIABETIC: Type: ☐ Pre ☐ 1 ☐ 2 Last A1C level: _____

***Do you have any of the follow conditions due to your diabetes:
☐ Kidney disease ☐ Neuropathy ☐ Eye Disease ☐ Dialysis ☐ NONE APPLY

INSURANCE, ASSIGNMENT AND HIPAA AUTHORIZATION

Co-payments are due at the time of service. We will bill all contracted insurance companies, however, you are ultimately responsible for all charges whether or not paid by your insurance company.
For your convenience we do accept: Checks, Cash and all Credit Cards.

I hereby authorize Neamand Foot & Ankle Center and/or its staff to disclose my individually identifiable health information to the insurance carrier(s).
Neamand Foot & Ankle Center will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance company to process the claims. This include disclosing your protected health information to other physicians who treat you or to your home health agencies that provide care to you.

I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Name : _____ Signature: _____ Date: _____

If the patient is unable to sign or is a minor, complete the following:

☐ Patient is a minor - if minor, please state age in years: _____ ☐ Patient is unable to sign

Guardian Signature : _____ Relationship: _____ Date: _____



DR. MARK E. NEAMAND - *Physician/Surgeon*

621 Devon Avenue Park Ridge, IL 60068 • neamandfootandankle.com • Phone:847-698-2895 • Fax:847-698-2942

At Neamand Foot and Ankle Center we are committed to providing you with the best possible care. In order to facilitate a smooth financial process, we have established the following financial policies.

Please read the attached information carefully. Do not hesitate to ask if you have any questions.

Insurance Verification/Coverage

We accept most major insurance plans however we are out of network for some.

It is important to provide us with accurate up to date insurance information.

Co-Pays and Deductibles

Co-pays, co-insurance and deductibles are due at the time of service. These amounts are determined by your individual insurance plan, and we encourage you to check with your insurance provider to understand your coverage.

Non-Covered Services and Non-Refundable Items

Please note that some services and in office purchases are **non-refundable**. We encourage you ask questions about such items/services before committing to a procedure or item.

24 Hour Cancellation Policy

We understand that circumstances can arise from time to time, preventing you from making your scheduled appointment. However, due to the demand for our services and need to manage schedules effectively, we request that you notify us as soon as possible. We kindly ask that you give our office 24 hours' notice if you need to cancel or reschedule. This allows us to offer the time slot to another patient in need of care.

Therefore, Late Cancellations and No Shows will result in a fee of **\$50.00**.

Please take the time to confirm your phone number and/or email to ensure you get appointment notifications.

We appreciate your understanding and cooperation in adhering to this policy. Our goal is to continue providing the high-quality care you have come to expect.

If you have any questions reading this policy, please do not hesitate to contact us 847-698-2895.

Signature of Patient

Date

Print Patient First & Last Name