REGISTRATION

DR. FLORENCE T. OUSKA-GRIFFIN

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PATIENT INFORMATION

Name

First **Initial** **Last**

Date

Home Telephone

Cell Telephone

Business Telephone

E-mail, please print:

Birth date Gender Male Female

Street address Unit

City State ZIP

Primary physician Tele

First MI Last

Emergency contact Tele

How did you find us? Insurance directory Yelp Google Web Other

Who may we thank for referring you?

INSURANCE

Please provide a copy of your insurance cards and a photo ID.

We will attempt to precertify your insurance coverage. If you have an unmet deductible, coinsurance or copayment, we may require a *deposit at the time of service* via cash, check, or credit card. We cannot assure the terms of your insurance coverage and you will be responsible for any unpaid balance as allowed under the terms of your policy.

I ATTEST THAT THE ABOVE INFORMATION IS TRUE
SIGNATURE

Date

SIGNATURE OF LEGAL GUARDIAN/AGENT IF APPLICABLE

Date

Confidential Patient Medical Information

Name Continued from registration _____

Describe your foot problem: _____

_____

_____

(Circle one) Right foot or Left foot or Both feet

How long have you had this problem? Number of Days:_____ Weeks:_____ Years: _____

Describe past treatment for this problem including any medication and/or injections:_____

_____

_____

ALLERGIES

Are you allergic to any medications? List:_____

What type of reaction do you have?_____

Are you allergic or sensitive to: (circle) Penicillin Sulfa Betadine (iodine)

Can you take aspirin or ibuprofen (Advil, Motrin)? Yes No

Have you had any problems with local anesthetics such as Novocain or Lidocaine? Yes No

GENERAL HEALTH

Do you smoke? Yes No

Do you drink alcohol or wine? Yes No If yes: (1-2 drinks per day) (1-2 per week) (1-2 per month)

Do you have Diabetes? Yes No If yes: # of years_____If yes: Do you take insulin: Yes No

Have you had any serious illnesses? Yes No Have you had any major surgeries? Yes No

PERSONAL PHYSICIAN

Are you under a physician's care? Yes No If yes, for what condition _____

Do you have a personal physician? Yes No If yes, date last seen _____

Have you seen other doctors in the past year? Yes No, If yes, for what _____

Have you seen another podiatrist in the past year? Yes No

May we contact your doctors about your health? Yes No

CONTINUED

Confidential Patient Medical Information (Continued)

Circle any of the following you have or had a problem with

Heart	Asthma	Skin	Unexplained weight loss
Circulation	Stomach ulcers	Gout	Frequent infections
High blood sugar	Hormones	Tuberculosis	Healing
High blood pressure	Anemia	Rheumatic Fever	Neurological disorder
Stroke	Bladder	Liver	Intestines
Cancer	Kidneys	Arthritis/Gout	Lungs

Do you have any artificial joints? Yes No If yes: Hip Knee Other

Do you have a heart valve implant? Yes No

Do you take antibiotics when you visit the dentist? Yes No

Family History

Mother: Living Deceased Cause of death _____

Father: Living Deceased Cause of death _____

Brother: Living Deceased Cause of death _____

Sister: Living Deceased Cause of death _____

Is there a Family History of:

Diabetes: Yes No

Rheumatoid Arthritis: Yes No

Psoriatic Arthritis: Yes No

Gout: Yes No

Employment Status

Employed Not employed Retired

At work do you mostly: Sit Stand Both standing & walking

Revised 08/2018

Patient Medication History Form

Name: Continued from registration

Pharmacy: **Telephone #**

Do you take a blood thinner such as Aspirin, Coumadin, Eliquis, Pradaxa, or Xarelto? Yes No

If yes, why?

Do you react to latex or rubber (gloves, balloons, etc.) ?	Yes	No
For female patients ONLY: Are you currently pregnant?	Yes	No

Prescription Drugs **Circle here if none**	**Strength** (such as 50 mg)	**Directions** (such as 2 tablets in the a.m.) State if taken only as needed
Over-the-Counter Medications (such as aspirin) **Circle here if none**	**Strength**	**Directions** (such as for headaches, when needed)
Vitamins, Minerals **Circle here if none**	**Strength**	**Directions** (such as one tablet each day)

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
TWO SIGNATURES REQUIRED

Our commitment to you

We will charge for only services rendered, supplies used, and equipment provided you. We will honor the terms of insurance contracts that we have signed. We will submit claims to your insurance company in a timely manner. We will strive to address your questions regarding financial matters related to your care. We will make reasonable efforts to refund amounts due you within ten days of determination by us that a refund is due you. We will put forth our best effort to provide you with a copy of all charges and payments to date upon your request without charge to you.

You accept the following terms by signing this Agreement

[Signature required prior to receiving treatment.]

You will provide us valid readable photo identification such as a driver's license or other official ID, and authorize us to make a copy for your medical file.

You agree to pay for those services rendered and not paid by your insurance company. We hold the option to request from you prior to rendering of services payment a deposit to be applied toward insurance deductibles, coinsurance/copay obligations and out of pocket amounts. Deposits may be required. [The latter applies to patients with traditional Medicare insurance only when you have signed an advance beneficiary notice.]. We cannot guarantee the terms of your insurance coverage. It is your responsibility to know your plan's benefits, requirements and exclusions for treatment. Your coverage is a contract between you and you insurance company.

We may require that you provide us a copy of a valid credit card to keep on file and by doing so authorize us to charge any outstanding balance following processing by your insurer for amounts due us.

You agree that we hold the option to charge the following fees and take the following actions on past due amounts for services rendered to you: 1) Bill you any balance due if your insurance company fails to process and make payment of a clean insurance claim within 45 days of the date sent. This shall apply to primary and secondary insurance claims including those for the State of Illinois, 2) Charge you a nonrefundable late fee of $25 should your patient balance become past due over 30 days from the date of the first patient invoice, 3) Charge you interest for past due amounts at an annual rate of 12% or the highest rate allowed under IL law if lower, 4) To direct an independent collections agency with whom we contract to take all such actions as allowed under law to collect amounts due us for balances over 45 days past due from the date of the first patient invoice, 5) Charge you an additional one-time nonrefundable fee equal to the fee charged to us by the collections agency as allowed under IL law, such fee equal to 30% or 35% of the past due balance depending on charges to us issued by the collections company.

CONTINUED ON OTHER SIDE

We may at our option refuse insurance coverage and/or refuse limits imposed on our fees from any insurance company with whom we do not contract. Such services shall be treated as cash, payment due at time of service.

We may charge a $25 no show fee for repeated cancellations of appointments without 24 hours advance notice to us by you. We will not charge for cancellations due to personal emergencies or inclement weather. Please do not venture out when the weather puts you at risk. You will not be charged a no-show fee.

I certify that if I chose to have charges for services billed to my insurance company, I have provided a true and correct copy of my current insurance identification card(s) and will provide information reasonably requested by this office or its billing company to process an insurance claim(s).

I understand that any modifications I make to this Agreement shall be deemed invalid by mutual agreement. I understand that my acceptance treatment from Dr. Florence Ouska-Griffin today and on any date in the future is sufficient evidence of my agreement to all the above terms without modification and shall become immediately binding even without my signature below.

I certify that I have read and agree to the above terms and conditions without modification.

Agreed to on this date
Patient _____ **Date:** _____
OR
Responsible party signature: _____ **Date:** _____

Authorization to release medical information

I hereby authorize the doctor and authorized staff to release of all information to secure the payment of benefits provided from this date forward. I authorize the use of this signature or a copy thereof for all services rendered to me on all insurance claims, my primary care physician, and/or other treating physician.

Agreed to on this date
Patient _____ **Date:** _____
OR
Responsible party signature: _____ **Date:** _____

In office original: 01/01/2009, last amended: 11/10/2014