PATIENT REGISTRATION

Mary Olszewski, DPM & Associates P.C.

We are glad to have you as a patient. Please answer the following.

PATIENT INFORMATION — PLEASE PRINT

Patient Name: (Last) (First) (MI)			
Date of Birth:	Sex: M F	Social Security Number:	
Address:			
City:	State: Zip:	**Personal Email:**	
Telephone Number: ( )		Cell Number: ( )	
Employer:		Work Number: ( )	
Name and telephone number of person we can call in an emergency:			
Who is financially responsible for your bill?			Relationship
Are you new to our practice?	How were you referred to our practice?		
Name of primary care doctor:			Phone: ( )
Address:			Fax: ( )
Name of pharmacy:			Phone: ( )
Address:			
What form would you like to be notified of upcoming appointments? Please Circle: Text Phone Call Email If phone or text, please indicate number: ( )			

FINANCIAL: I understand and agree (regardless of my insurance status) that I am responsible for the balance of my account for any professional service redered. I certify that the above information is true and correct to the best of my knowledge.

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Mary Olszewski DPM & Assoc. for services rendered.

INFORMED CONSENT: I authorize Mary Olszewski DPM & Assoc. to provide any treatment we find necessary in my plan of care. I consent to the use and disclosure of my personal health information necessary for treatment, payment and health care operations

Patient/Guardian Signature: _____ Date: _____ FP_____

REVIEW OF SYSTEMS

Mary Olszewski, DPM & Associates P.C.

Please answer the following.

Patient Name: _____ Date: _____
(Last) (First) (MI)

1. Do you, yourself have any medical problems or illnesses? _____

Do you have a history of the following:

Diabetes	Yes	No	Insulin/Pill/Diet	Yes	No
Heart Problems	Yes	No	Stomach Problems (Ulcer)	Yes	No
Heart Attack	Yes	No	Liver Disease	Yes	No
Stroke	Yes	No	Kidney Disease	Yes	No
High Blood Pressure	Yes	No	Cancer/Chemotherapy	Yes	No
Asthma	Yes	No	Hepatitis (A,B,C)	Yes	No
Mitral Valve Prolapse	Yes	No	Prescription Blood Thinner	Yes	No
			Coumadin/Warfarin, Plavix, Pradaxa, Yarelto, Jantoven, Marevan (Circle one)		

2. Do any of the following illnesses run in your family? (Please circle all that apply- Mom, Dad or both)

Diabetes: Mom Dad **Heart Attack:** Mom Dad **Stroke:** Mom Dad **Cancer:** Mom Dad

High Blood Pressure: Mom Dad **Ulcers:** Mom Dad **Liver Disease:** Mom Dad **Kidney Disease:** Mom Dad

3. Allergies: _____

Reaction: _____

4. Surgeries in the past 5 years: _____

Foot/Ankle Surgeries: _____

5. Have you had any problems with: (Please circle all that apply)

Eyes & Head: macular degeneration, glaucoma, fainting, headaches

Ears: ringing of ears, dizziness, hearing loss

Respiratory: emphysema, shortness of breath

GI: ulcer, intestinal problems

Skin: non-healing sores, eczema, psoriasis, rash

Joints: rheumatoid arthritis, degenerative arthritis, joint implants

Muscles: fibromyalgia

Neurologic: drop foot, Parkinson's Disease, tingling, burning, numbness

6. Have you ever smoked: _____ packs per day _____ Years _____

Do you drink alcohol?: _____ drinks per day _____

Name: ______________________________ Pharmacy Name: _________________

Date: _________________

MEDICATIONS

Pharmacy #: _________________

Please list ALL medications you have taken below and check current or discontinued.

Medication	Current	Discontinued

Mary Olszewski, DPM & Associates P.C.

Office Financial Policy

The doctors are committed to providing you with the best possible podiatric care. Charges for services rendered have been determined based on usual and customary fees for the area. If you have questions regarding your bill, please contact our billing office at 847-770-6057.

Payment for services is due at the time of service. We accept cash, check, Mastercard, Visa and Discover. However, as a *courtesy*, we will file insurance claims on behalf of our patients enrolled with insurance companies in which we have a contract to participate.

Your health insurance is a contract between *you* and *your insurance company*. You are responsible for the balance not paid by the insurance company. Please be aware that some services may not be covered by your insurance policy.

We send out statements with balances due on the first of every month. Payment is due in full upon receipt of this statement unless you have made other financial arrangements with our billing staff. Accounts past due greater than one month will be assessed a $10.00 finance charge per month until fully paid. In the event of no response, after three months, your account will be turned over to our collection agency. *All fees incurred including agency fees, court costs and attorneys' fees become your responsibility.*

A 24-hour cancellation is required. *Patients who miss scheduled appointments without a minimum of 24 hours' notice will be charged $50.00.*

Cancellation of outpatient surgeries ***require a minimum of 7 days notice****. Outpatient surgeries cancelled with less than 7 days notice will be charged $150.00.*

Thank you for your cooperation regarding our Financial Policy. Please call us if you have any questions.

Billing Office

I have read and agree to the above Financial Policy.

Signature of Patient/Responsible Party Date