



H. CRAIG FOX, DPM

PLEASE PRINT

PATIENT INFORMATION

Thank you for selecting Fox River Foot and Ankle Centers, P.C.! Dr. Fox and Staff will strive to provide you with the best Podiatric care. To help us meet this goal, please fill out this form. If you need any assistance, please ask us - we will be happy to help! All information must be filled out in full

Today's date:					
Patient's last name:		First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Birth date:	Age:	Sex: M F	Is this patient a minor? Yes No If yes please fill out parents information.		
Street address:		SSN:	Home phone no.: ()		
Cell Phone no.: ()			Work phone no.: ()		
P.O. box:	City:	State:	ZIP Code:		
Whom may we thank for your referral (please check one box):				<input type="checkbox"/> Dr.	
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Office Sign	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Other
Occupation:					
Employer:					
Primary Care Physician and Phone Number:					
Date Last Seen:					
Primary Care Physician's Address:					
Pharmacy of Choice:					
Patient Shoe Size:			Email address:		
Other family members seen here:					
Patients Mother's Info/Spouse Info (if minor or applicable)		Birth date:	Address (if different):	Home phone no.:	
		/ /		()	
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Social Security #	
Occupation:	Employer:	Employer address:		Employer phone no.:()	
Patients Father's Info (if minor)		Birth date:	Address (if different):	Home phone no.:	
		/ /		()	
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Social Security #	
Occupation:	Employer:	Employer address:		Employer phone no.:()	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please note: In cases of divorce, the undersigned agrees that any amount remaining unpaid after insurance will be the responsibility of the parent who brings the child for his/her appointments.

Primary Insurance Name / No HMOS are accepted as we do not participate . If your plan is HMO, payment for services will be required on day of service.					
Subscriber's name:	Subscriber's S.S. no.:	DOB	Group #:	Policy no.:	Co-payment:
		/ /			\$
Employer:	Address:			Phone:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Secondary Insurance Carrier					
Subscriber's name:	Subscriber's S.S. no.:	DOB	Group #:	Policy no.:	Co-payment:
		/ /			\$
Employer:	Address:			Phone:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:	
			()	()	
<p>I authorize Dr. H. Craig Fox and the staff of Fox River Foot & Ankle Center P.C. to treat me for my Foot and Ankle (Podiatric) problems. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I <u>am financially responsible for any balance remaining after insurance has paid</u>. I also authorize Fox River Foot & Ankle Center P.C. or my insurance company to release any information required to process my claims. I acknowledge that I have received Notice of Privacy Practices which are in compliance with HIPPA.</p>					
I hereby agree to the following terms and conditions:					
<p>Any balance remaining after insurance will be due 21 days after the date of the invoice from Fox River Foot & Ankle Center P.C.. There will be a \$30.00 service charge added for each check tendered in payment that is not honored for any reason. I agree that if my account becomes delinquent, I will pay a collection fee of 25% of the total owed when sent to collection, all attorney fees, and court costs incurred by the creditor. I have read and understand this authorization in its entirety.</p>					
<i>Patient/Guardian signature</i>			<i>Date</i>		

Podiatric History and Physical

Patient Name: _____

About your Problem

What is the location of your foot or ankle problem? _____

How long has the problem been present? _____ Years _____ Months
_____ Weeks _____ Days _____ Other: _____

What type of pain are you having? _____ Sharp _____ Dull _____ Throbbing

Explain when this happens _____

Describe the nature of the pain _____ New onset _____ Constant _____ Intermittent
Explain: _____

Have you ever had treatment before: If yes, where? _____

What type of treatment was completed for your problem? _____

Have you noticed any knee or lowerback pain? _____

About your Medical History

Do you have any allergies to any medication(s)? _____

What type of medication(s) are you on now? _____

What type of medical problems do you have? _____

Have you had any surgery of any kind in the past? _____

Do you smoke? If yes, how much? _____

Dr. Fox will make every effort to explain your diagnosis and treatment option to you. If for any reason you do not understand something, please stop the doctor. Ask all of the questions you need to feel comfortable.

Dr. Fox is here for you.

Fox River Foot & Ankle Centers P.C.
Fox River Ambulatory Outpatient Inc.
3963 Route 34 Oswego IL 60543
Phone: 630-551-3338
Fax: 630-551-4117

810 E. Division
Coal City IL 60416
Phone: 815-634-2324
Fax: 815-634-2343

2081 Ridge Road, Suite 113
Minooka IL 60447
Phone: 815-521-9347

Legal Assignment of Benefits and Release of Medical and Plan Documents

I, the undersigned, have insurance and/or employee health care benefits coverage with _____ . In consideration of the medical services to be provided, I hereby assign and convey directly to Dr. Howard C. Fox (the doctor), Fox River Foot & Ankle Centers P.C. and Fox River Ambulatory Outpatient, Inc., all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 60 days from the date of insurance payment and/or denial and if outside collection attempts are necessary, I will also be responsible for all collection costs and reasonable legal fees. I hereby authorize the doctor and clinic to release all medical information necessary to process this claim.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from reimbursement of any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

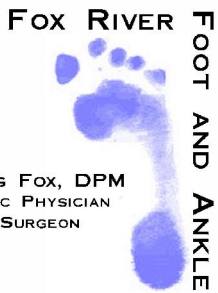
I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian _____ Date: _____

Relationship of Guardian to Minor Child: _____



H. CRAIG FOX, DPM
PODIATRIC PHYSICIAN
AND SURGEON

OSWEGO * COAL CITY
Minooka

3963 Rt. 34
Oswego, IL 60543
PH:(630) 551-FEET
(3338)
fax: (630) 551-4117

810 E. Division
Coal City, IL 60416
Ph:(815) 634-2324
Fax: (815) 634-2343

2081 Ridge Road, Suite 113
Minooka, IL 60447
PH: 815-521-9347

RELEASE OF PRIVATE HEALTH INFORMATION

TO: H. CRAIG FOX, DPM and FOX RIVER FOOT & ANKLE CENTER P.C.

To ensure proper and timely handling of your medical information, please provide us with the following information:

Home #:	
Work #:	
Day Phone #:	
Alternate Phone:	

I authorize the above named physician and Fox River Foot & Ankle P.C. to release any and all medical test results or other medical private health information relating to my treatment to:

Please initial your choices that are acceptable to you. If you do not want an option, please leave it blank to indicate we do not have your permission to use that choice.

- May leave message at work to call the office.
- May leave a message on answering machine/voice mail to call office.
- May leave a message with a family member to call the office.
- May leave test results on answering machine/voice mail.
- May give test results to designated person:
Name: _____
Relationship: _____
- May release test results only to myself.

I understand this Release will be in effect unless changed or revoked by myself either in writing or by completing a new Release.

Date:	
Patient Name:	
Address:	
Date of Birth:	
SS#:	
Signature:	

Witness: _____

Podiatric Pain Analysis Survey

H. Craig Fox, DPM

Fox River Foot & Ankle Center

PODIATRIC MEDICINE • SPORTS MEDICINE



H. CRAIG FOX, DPM

Name: _____

Height: _____ Diabetic? Yes or No (circle one)....Insulin/Medication/Diet (circle one)
Weight: _____ Smoker? Yes or No (circle one)...If Yes, Amount Per Day _____
Drug Allergies/What occurred? _____
Email address: _____

Please check any of the following conditions you are currently experiencing or suffering from:

- | | |
|--|---|
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Pain in feet or legs with exercise or activity R/L/Both |
| <input type="checkbox"/> Heel or Arch Pain R/L/Both | <input type="checkbox"/> Feet/Toes feel numb R/L/Both |
| <input type="checkbox"/> Leg pain (shin splints) R/L/Both | <input type="checkbox"/> Foot/Toes/Legs burn R/L/Both |
| <input type="checkbox"/> Achilles tendon pain R/L/Both | |
| <input type="checkbox"/> "Toe-in" or "Toe-out" gait (walking) | <input type="checkbox"/> Discoloration of toes/foot R/L/Both |
| <input type="checkbox"/> Ankle swelling or stiffness R/L/Both | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Non / Poor healing sore on the leg or foot R/L/Both |
| <input type="checkbox"/> Ankle instability (easy twisting injuries) | |
- R/L/Both**
- Do your legs feel heavy, tired, restless, or achy **R/L/Both**
 - Have you had a Deep Vein Thrombosis (DVT) and are experiencing pain, swelling **R/L/Both**
 - Pain with first step in the morning
 - Pain in the Ball of Foot

Nail Problems

<input type="checkbox"/> Yellowed	<input type="checkbox"/> Thick	<input type="checkbox"/> Painful
<input type="checkbox"/> Discolored	<input type="checkbox"/> Ingrown	

Please answer the following about the above conditions:

Do the above conditions disrupt your lifestyle and activities of daily living? Yes / No

Did the condition result from accident or injury? If so, please detail:

Is this condition causing or are you suffering with any of the following:

Tingling/Numbness in:

- Legs R / L
- Ankle R / L
- Feet R / L

Pain radiating into:

- Ankle R / L
- Feet R / L
- Toes R / L

Difficulty with:

- Standing Bending
- Walking Lifting
- Sitting Kneeling

Nature of pain: Sharp / Dull / Throbbing / Constant / Intermittent

How long have you been suffering with this condition? Days / Weeks / Months / Longer

Is this condition affecting your ability to perform daily tasks? Yes / No

Please check any prior treatments received:

- Injections Orthotics Temporary over the counter inserts
- Non-steroidal anti-inflammatory medication Braces/immobilizers
- Physical Therapy Ice Rest

Patient Signature

Date