Diana Emini, DPM
Michelle Kim, DPM

14236 McCarthy Rd, Lemont IL 60439
www.DMFootAndAnkle.com

Today's Date: / /

PATIENT INFORMATION FORM

Name		Preferred Name	
Gender ☐ M ☐ F	Birth Date / /	Social Security # - -	
Address		City	State
Zip Code -	Email		
Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -	
Would you like to receive text messages for appointment reminders? ☐ Yes ☐ No			
What is your preferred contact method from our office? ☐ Home ☐ Cell ☐ Work ☐ Patient Portal			
Primary Language Spoken ☐ English ☐ Other:		Race/Ethnicity	
Marital Status ☐ S ☐ M ☐ D ☐ W ☐ DP			
Primary Care Physician	Phone ( ) -	Last Seen / /	
Pharmacy Name	Location		
Employer	Occupation		
Who is in charge of your medical management? ☐ Self ☐ Other:			
Emergency Contact Name	Relationship	Phone ( ) -	

INSURANCE INFORMATION

Primary Insurance:	☐ Aetna	☐ BCBS	☐ Cigna	☐ Humana	☐ Medicare	☐ Other:
Secondary:	☐ Aetna	☐ BCBS	☐ Cigna	☐ Humana	☐ Medicare	☐ Other:

Member's Name: Member's Date of Birth: / /

If the patient is a minor (17 and under), name of guarantor or responsible party:

HOW DID YOU HEAR ABOUT US? (Please check all that apply)

Internet Search: ☐ Google using key words _____ ☐ Website ☐ Facebook / Social Media

Referral: ☐ Friend/Patient Name _____ ☐ Doctor _____

Local Ad: ☐ Val Pak ☐ Lemont Life

Phone Book: ☐ Home Pages from the town of _____

Church Ad: ☐ St. Al's ☐ St. Cyril's ☐ St. Pat's

Other: ☐ Walk-in / Saw Sign ☐ Insurance Site ☐ Other _____

Providing comprehensive, quality foot care for the entire family.

Allergies

☐ No known allergies

☐ No known drug allergies

I am able to take NSAIDs (Advil, Aleve, Aspirin, ibuprofen)

☐ Yes ☐ No: _____

Allergy / Intolerance	Reaction	Severity
		mild mod severe
		mild mod severe
		mild mod severe
		mild mod severe

Medications

Please list all medications and supplements you are taking, or you may provide a complete separate list.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Past Medical & Surgical History

	Condition	***Diagnosis Year***		***Condition***	***Diagnosis Year***		***Condition***	***Diagnosis Year***
☐	AIDS / HIV		☐	Frostbite		☐	Peripheral Neuropathy	
☐	Anemia		☐	GERD / Acid Reflux		☐	Peripheral Vascular Disease	
☐	Anxiety / Depression		☐	Gout		☐	Polio	
☐	Arthritis		☐	Headache/Migraine		☐	Pulmonary Embolism	
☐	Asthma		☐	Heart Disease		☐	Raynaud's Disease	
☐	Back Pain / Sciatica		☐	Hepatitis A / B / C		☐	Rheumatoid Arthritis	
☐	Bleeding Disorder		☐	Hernia		☐	Seizures / Epilepsy	
☐	Blood Clots / DVT		☐	Hypertension (Blood Pressure)		☐	Stroke / CVA	
☐	Cancer		☐	Kidney Disease		☐	Substance Abuse	
☐	Diabetes - Type 1 / 2		☐	Leg / Foot Ulcers		☐	Thyroid Problems	
☐	Dialysis		☐	Liver Disease		☐	Tuberculosis	
☐	Dyslipidemia (High Cholesterol)		☐	Lung Disease		☐	Varicose Veins	
☐	Environmental allergies		☐	Organ Transplant		☐	Other:	
☐	Fibromyalgia		☐	Osteoporosis		☐	Other:	
☐	Foot Deformity		☐	Pacemaker / Defibrillator		☐	Other:	

	Surgery	***Year***		***Surgery***	***Year***		***Other Surgery***	***Year***
☐	Anesthesia problems		☐	Leg stent / bypass R / L		☐	Cataracts	
☐	Heart bypass / stent		☐	Vein Procedure		☐		
☐	Hip Replacement R / L		☐	Foot/Ankle		☐		
☐	Knee replacement R / L		☐	Foot/Ankle		☐		

Other Medical History

Do you smoke? ☐ Yes ☐ No

If yes: _____ packs per day

Smoke/history of smoking for: _____ years

Alcohol intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit drug use: ☐ None ☐ _____

Special diet: ☐ No ☐ Yes : _____

Activity level at work: ☐ Sitting ☐ Walking ☐ Standing ☐ Driving

Exercise level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Sporting activities: _____

Difficulty walking or climbing stairs? ☐ No ☐ Yes

Are you able to care for yourself? ☐ No ☐ Yes

Legally blind in one or both eyes? ☐ No ☐ Yes

Height: _____

Weight: _____

Shoe size: *Right* _____ *Left* _____

Major medical conditions in your family:

☐ Unknown

☐ Mother: _____

☐ Father: _____

☐ Sibling: _____

☐ Other: _____

Reason For My Visit Today

Please list up to 2 conditions, with #1 being the most important.

1) Reason for my visit: _____ **Location:** _____

Symptoms: _____

How often is this bothering you? _____ **Possible cause:** _____

What makes it feel worse? _____

How long have you had this: _____ days wks mos yrs **Severity**: mild moderate severe. Pain + / 10

Any past treatments: _____

2) Reason for my visit: _____ **Location:** _____

Symptoms: _____

How often is this bothering you? _____ **Possible cause:** _____

What makes it feel worse? _____

How long have you had this: _____ days wks mos yrs **Severity**: mild moderate severe. Pain + / 10

Any past treatments: _____

Review of Systems

Please circle all the symptoms you have had in the past 3 months, otherwise check "None."

General:	Fatigue	Nausea	Vomiting	Fever	Chills	Excessive weight gain / loss	☐ None
Hematologic:	Anemia	Easy bruising	Excessive bleeding				☐ None
Neurologic:	Dizziness	Falls	Imbalance	Loss of sensation	Numbness	Tingling	☐ None
Vascular:	Cold feet	Calf pain	Leg cramps	Swelling of legs/feet	Varicose legs		☐ None
Dermatologic:	Corn / callus	Moles	Ingrown nail	Skin growths / lesions			☐ None
	Sores	Warts	Rash / itching	Toenail abnormalities / changes			
Musculoskeletal:	Back pain	Ankle pain	Foot pain	Toe pain	Difficulty walking		☐ None
	Flat feet	Instability	Intoeing	Stiffness	Weakness		

DIANA EMINI, DPM
MICHELLE KIM, DPM

PATIENT CONSENT & RELEASE FORM

AUTHORIZATION OF PAYMENT TO PHYSICIAN
I hereby assign all insurance benefits payable directly to DM Foot & Ankle Associates for services rendered. I understand I am financially responsible and liable for services rendered, regardless of insurance payment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)
I acknowledge that I was provided a copy of DM Foot & Ankle Associate's privacy Practices. I have read, or had the opportunity to read if I so chose, and understand this notice.

MEDICAL HISTORY FORM
All medical history I provide each visit is true to the best of my knowledge.

FINANCIAL POLICIES
I have read the office policies and agree to their contents.

PHARMACY
I authorize DM Foot & Ankle Associates to obtain my medication history directly from my pharmacy.

- ☐ Yes. I understand that my medication history will be updated from my pharmacy as it is available.
- ☐ No. I will provide a written list of my current medications and keep this list updated.

AUTHORIZATION FOR USE OF PHOTOS
On occasion, medical photographs of my condition may be taken in the office. Photos may be used for medical documentation, before and after photos, wounds, surgeries, or other conditions. These photos may be part of the medical record, used in case studies or journals, used in teaching, or used in advertisements. Any identifying name, face, or other information will not be used.

I authorize my photos to be used for:

- ☐ Medical records only
- ☐ Medical records, studies, teaching, and advertising (no identifying information)

I have read and fully understand this form and all of its associated contents. This authorization is valid as of today and will remain in effect while I am a patient of DM Foot & Ankle Associates.

_____	_____	_____
Printed Name of Patient	Signature of Patient / Guardian	Date