Diana Emini, DPM
Michelle Kim, DPM

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

Today's Date: / /

PATIENT INFORMATION FORM

Name		Preferred Name	
Legal Sex ☐ F ☐ M	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	Pharmacy 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	☐ Lovin' Lemont Livin'
Phone Book:	☐ Home Pages		
Church Ad:	☐ St. Al's	☐ St. Cyril's	☐ St. Pat's	☐ Previous Patient
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***
☐	AIDS / HIV	
☐	Anemia	
☐	Anxiety / Depression	
☐	Arthritis	
☐	Asthma	
☐	Back Pain / Sciatica	
☐	Bleeding Disorder	
☐	Blood Clots / DVT	
☐	Cancer	
☐	Diabetes - Type 1 / 2	
☐	Dialysis	
☐	Dyslipidemia (High Cholesterol)	
☐	Environmental allergies	
☐	Fibromyalgia	
☐	Foot Deformity	

	Condition	***Diagnosis Year***
☐	Frostbite	
☐	GERD / Acid Reflux	
☐	Gout	
☐	Headache/Migraine	
☐	Heart Disease	
☐	Hepatitis A / B / C	
☐	Hernia	
☐	Hypertension (Blood Pressure)	
☐	Kidney Disease	
☐	Leg / Foot Ulcers	
☐	Liver Disease	
☐	Lung Disease	
☐	Organ Transplant	
☐	Osteoporosis	
☐	Pacemaker / Defibrillator	

	Condition	***Diagnosis Year***
☐	Peripheral Neuropathy	
☐	Peripheral Vascular Disease	
☐	Polio	
☐	Pulmonary Embolism	
☐	Raynaud's Disease	
☐	Rheumatoid Arthritis	
☐	Seizures / Epilepsy	
☐	Stroke / CVA	
☐	Substance Abuse	
☐	Thyroid Problems	
☐	Tuberculosis	
☐	Varicose Veins	
☐	Other:	
☐	Other:	
☐	Other:	

	Surgery	***Year***
☐	Anesthesia problems	
☐	Heart bypass / stent	
☐	Hip Replacement R / L	
☐	Knee replacement R / L	

	Surgery	***Year***
☐	Leg stent / bypass R / L	
☐	Vein Procedure	
☐	Foot/Ankle	
☐	Foot/Ankle	

	Other Surgery	***Year***
☐	Cataracts	
☐		
☐		
☐		

Other Medical History

Height: _____ ' _____ " Weight: _____ lbs Shoe size: *Right* _____ *Left* _____

Major medical conditions in your family:

- ☐ Unknown
- ☐ Mother: _____
- ☐ Father: _____
- ☐ Sibling: _____
- ☐ Other: _____

Cigarette Smoking Use: ☐ Never ☐ Former smoker for _____ yrs ☐ Current smoker: _____ yrs _____ PPD
Chewing Tobacco Use: ☐ Never ☐ Former user for _____ yrs ☐ Current user: _____ yrs Type:
Vaping/E-cigarette Use: ☐ Never ☐ Former user for _____ yrs ☐ Current user: _____ yrs

Alcohol intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Illicit drug use: ☐ None ☐ _____ ☐ Medical marijuana
Special diet: ☐ No ☐ Yes : _____

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

Reason For My Visit Today

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

1) Reason for my visit: _____ **Location:** _____
How long have you had this: _____ days wks mos yrs **Severity**: mild moderate severe. Pain levels: + / 10
Symptoms: _____
What makes it feel worse? _____
How often is this bothering you? _____ **Possible cause:** _____
Any past treatments: _____
Any treatment goals: _____

2) Reason for my visit: _____ **Location:** _____
How long have you had this: _____ days wks mos yrs **Severity**: mild moderate severe. Pain levels: + / 10
Symptoms: _____
What makes it feel worse? _____
How often is this bothering you? _____ **Possible cause:** _____
Any past treatments: _____
Any treatment goals: _____

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.

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

PHARMACY
In order to ensure an accurate prescription history, all medications from the past eighteen months will be directly updated to the my medical chart from my preferred pharmacy.

REVIEWS
I authorize any reviews or comments to our surveys to be posted on our website or internet with use of my first name only.

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 never be used.

I have read and fully understand this form and all 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