DR. SCOTT O'CONNOR
Fellow, American College of Foot & Ankle Surgery
Diplomate, American Board of Podiatric Surgeons
Certified in Foot, Reconstructive Rearfoot/Ankle Surgery

Patient's Last Name ____ **First Name** ____ **MI** __ **Date of Birth** ___/___/____ **Age** ____ **Sex** ____ **Social Security Number** ____

Street Address ____ **City** ____ **State** ____ **Zip** ____

Patient's Employer ____ **Home Phone** (___)____-_______ **Cell Phone** (___)____-_______ **Work Phone** (___)____-_______

Financially Responsible Party- Same as above? Yes____ No _____

Last Name ____ First Name ____ MI __ Date of Birth __/__/____ Age ____ Sex ____ Social Security Number ____

Street Address ____ City ____ Home Phone (_____)______-___________

Patient's Employer ____ Work Phone (_____)______-___________ Cell Phone (_____)______-___________

Insurance Information – PLEASE PRESENT CARD FOR COPYING

Primary Insurance-__________________ ***Secondary Insurance***-________________________

Policy Holder Name- __________________ **D.O.B.** - ______________________

Emergency Contact : Name_________________ Phone_____-_________ Relationship_________

How did you find out about our office? Relative or Friend (Name)___________________________

Yellow Pages_____(Yellow Book or Verizon) Sign ____Insurance____ Radio ____Prairie Thunder Hockey____

Doctor Referral (Name)_____________________ Website_____ Other (specify)__________________

Treatment Authorization and Consent to Release Private Health Information

I hereby authorize treatment by Central Illinois Foot & Ankle Center. I understand that my healthcare information is private and that my insurance carrier will require this information in order to process claims for payment of services rendered by this medical provider. I authorize the release of pertinent information to my insurance carrier(s). I also authorize payments to be made directly to this medical provider by my insurance carrier(s).

X______________________________ Signature of Responsible Party ______________ Date

Financial Agreement

I agree that I am responsible to pay co-pay amounts, deductibles and services not covered by my insurance company. I also understand that I will be responsible for any expense associated with the collection of a debt owed to the provider by me (i.e. attorney fees, court fees, collection agency). I understand that if any unpaid balance is turned over to our collection agency that a fee ranging from 33%-50% will be added to the total balance due. I also understand interest may be charged on all accounts, which are 30 days or more past due, at a rate of 1.5% per month, annual rate of 18%. I also understand that financial charges will be added to any account I have that is 90 days or more past due and here-by agree to pay such charges if levied.

X______________________________ Signature of Responsible Party ______________ Date

Central Illinois Foot & Ankle Center
Permission Form

I ___________________________________ give Dr. Scott O'Connor____D.P.M.
Patient's Name Doctor's Name

My permission to:

	YES	NO
1. Leave medical information on answering machine, voicemail, etc.	____	____
2. Leave medical information with family members listed below.	____	____
3. Release medical records to the following individuals listed below	____	____

___/___/______

- **Please list individual by name**
- **Anyone not listed will not be given access to your medical records or information**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

____ ________________________
Patient Name (please print) **Date**

____
Parent or Authorized Representative (if applicable)

____
Signature

Insurance Certification

Date Called: ____/____/_______ Contact Name: ___________________

Coverage in Effect? Yes No

Deductible? Yes No Reset Date: _____/_____/_______

Amount: $__________ Amount Met to Date: $_____________

Copay/Coinsurance? Yes No Amount? __________________

Policy Limits? ____

Dme Limits? ____

Foot Exclusions? ____

Specific coverages:

Custom Molded Orthotics (L-3000): Yes No Amounts: __________________

Diabetic Shoes (A5500, A5512): Yes No Amounts: __________________

Front Back

PREMIER PODIATRY

PROGRESS NOTES

DATE

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______________________________ ___/___/_____ ____ _____lb ____________ _________
Name Today's Date Age Weight Height Shoe Size

______________________ ____/____/______ ____
Family physician Date Last Seen Doctor's Address

______________________ _______________ Do/Have you had Orthotics or Diabetic Shoes? ________________
Specialist For What Condition

What kind of Foot/Ankle Problem? Right Left____
____ For How Long? _________________

Review of Symptoms

Do you have an excessive: Thirst? Yes/no Hunger? Yes/no Urination? Yes/no
Any difficulties healing cuts or infection? Yes/no Explain____________________________
Do you bleed easily or on a **blood thinner**? Yes/no Explain_________________________
Do you have a stomach **ulcer**? Yes/no Is there active bleeding? Yes/no
Have you had problems with: (please check all that apply)

____Skin/Hair	____Eyes/Ears	____Heart	____GI Tract	____Blood
____Bladder/Kidney	____Bleeding	____Muscle	____Gout	____Seizure
____Neurological	____Stroke	____Bleeding	____Clotting	____Heart Attack
____Extremities	____Liver Disease	____Kidney	____DVT	____Anesthesia

If you checked any of the above, please explain further: ________________________________
____

Past Medical History

Current Medications-Name/Dosage/Frequency ☐See Attached List
1___________________2___________________3___________________4___________________
5___________________6___________________7___________________8___________________
Any **medical** problems or diseases?____
Any **allergic** reactions to: 1.Medications? Yes/no 2. Iodine? Yes/no 3. Tape? Yes/no
Please Explain? ____
Are you **Diabetic**? Yes/no If yes, how is it controlled? ______________________________

Past Family History

Any significant family medical history? ____
Which member of your family? Mother____ Father____ Brother ____ Sister____ Other______

Social History

Do/Did you smoke? Yes/no How Much? ________ How Long? _________
Do/Did you drink? Yes/no How Much? ________ How Long? _________
Any addictions to: Drugs? Yes/no Alcohol? Yes/no Painkillers? Yes/no

Surgical History

Have you had any surgeries? Yes/no Explain? ______________________________________
Have you or family had a reaction to anesthesia? Yes/no Explain? ______________________
Have you had heart valve or joint replacement? Yes/no Explain? ________________________
Is there any pertinent conditions not previously mentioned? Yes/no Explain? ____________

PF= 1-5 DPF= 12+ **Right/Left Count Separate**
EPF= 6-12 CPF= 18+ **#Bullet Possible=19**

CONSTITUTIONAL:

- **Measure (3-7): HT______WT______BP**
  Sit______/______Stand______/______P______R______T______
- **Appearance: WNL Well Nourished Obese Malnourished Groomed Disheveled**

CARDIOVASCULAR:

- **Palpation/Observe:**
  Pulse R DP 0 1 2 3 4 Non/Palpable L DP 0 1 2 3 4 Non/Palpable
  R PT 0 1 2 3 4 Non/Palpable L PT 0 1 2 3 4 Non/Palpable
  CFT<3_______ CFT<3_______
  Edema R + - _______ Pitting_______mm
  L + - _______ Pitting_______mm

LYMPHATIC:

- **Palpation: WNL Enlarged Tender NonTender Absent Popliteal/Inguinal**

SKIN:

- **Inspect/Palpate: R-Nails WNL Discolored- 1 2 3 4 5 Dystrophic- 1 2 3 4 5 Clubbed Long**
  Ingrown-1 2 3 4 5 tib/fib Cyanotic Infected- 1 2 3 4 5 tib/fib
  L-Nails WNL Discolored- 1 2 3 4 5 Dystrophic 1 2 3 4 5 Clubbed Long
  Ingrown-1 2 3 4 5 tib/fib Cyanotic Infected- 1 2 3 4 5 tib/fib

  R Xerotic + - WNL Scaly + - Turgor + -
  L Xerotic + - WNL Scaly + - Turgor + -

NEUROLOGIC/PSYCHIATRIC:

- **Coordination: WNL Heel/Knee/Shin + - Rhomberg + -**
- **DTR's + - R L B Babinski + - R L B**
- **Epicritic: Sharp/Dull + - R L B Vibratory/Proprioception + - R L B**
  Protective + - R L B
- **Mental Status: Oriented X 3 (Time, Place, Person) Not Oriented**
- **Mood: Calm Depressed Agitated Anxious Disinterested**

MUSCULO-SKELATAL: Appearance: HI Neutral Flat Very Flat

- **Gait: WNL Antalgic Guarded Steppage A/Propulsive**
- **Inspection/Palpation: (Digit/Nails) R WNL Contracted Clubbed Ischemic Petichial**
  (Digit/Nails) L WNL Contracted Clubbed Ischemic Petichial
- **ROM: R- WNL**
  Tracking_____Crepitus_____Pain_____Semirigid_____Flexible_____
  L- WNL
  Tracking_____Crepitus_____Pain_____Semirigid_____Flexible_____
- **Stability: R WNL Congruous Dislocated Subluxed**
  L WNL Congruous Dislocated Subluxed
- **Strength: R- Evertors 0 1 2 3 4 5 L- Evertors 0 1 2 3 4 5**
  Invertors 0 1 2 3 4 5 Invertors 0 1 2 3 4 5
  Dorsiflexors 0 1 2 3 4 5 Dorsiflexors 0 1 2 3 4 5
  Plantarflexors 0 1 2 3 4 5 Plantarflexors 0 1 2 3 4 5

PMT-
Lesions-

Patient Name:_____________________________Doctor:_________________________Date:______________