**NORTHWEST SUBURBAN FOOT & ANKLE CLINIC**

**STEVEN T. ADELSTEIN, DPM, FACFAS**

**ADAM D. GOLDKIND, DPM, FACFAS**

**SYED A. HUSSAIN, DPM, AACFAS**

St. Alexius Medical Center Elk Grove Foot Clinic

Doctor’s Bldg. 2, Suite 305 1139 Nerge Road

1585 N. Barrington Road Elk Grove Village, IL 60007

Hoffman Estates, IL 60169 Tel: (847) 923-1280

Tel: (847) 310-8100 Fax: (847) 923-1281

Fax: (847) 310-8156

**~WELCOME TO OUR OFFICE~**

**Patient's Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_

Home Phone # ( ) \_\_\_\_\_\_\_\_\_\_ Cell # ( ) \_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # ( ) \_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec. # \_\_\_ - \_\_\_ - \_\_\_\_ Date of Birth \_\_/\_\_/\_\_ Age \_\_\_ Sex: M F Status: S M D W

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # ( ) \_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Holder Information**:

Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_ Zip Code \_\_\_\_\_\_ Telephone # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec. # \_\_\_ - \_\_ - \_\_\_\_ Date of Birth \_\_/\_\_/\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Holder Information:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_\_ Telephone # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec. # \_\_\_ - \_\_ - \_\_\_\_ Date of Birth \_\_/\_\_/\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How Were You Referred To This Office?**

Doctor Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Hospital Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Internet/Web Site (which one?) \_\_\_\_\_\_\_\_\_\_\_\_\_

Yellow Pages (which one?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**~MEDICAL INFORMATION~**

Patient's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your foot/ankle problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in good health? Yes \_\_\_ No \_\_\_ Have you had any serious illness or operations? Yes \_\_\_ No \_\_\_\_

Is there any personal history of diabetes? Yes \_\_\_ No \_\_\_ Is there family history of diabetes? Yes \_\_\_ No \_\_\_

Have you ever been treated for : Asthma \_\_\_ Epilepsy \_\_\_ Heart Problems \_\_\_ Poor Circulation \_\_\_

High Blood Pressure \_\_\_ High Cholesterol ­­­­\_\_\_ Kidney/Liver Problems \_\_\_ Stomach/Bowel Problems \_\_\_ Osteo/Rheumatoid Arthritis \_\_\_

Do you smoke? Yes \_\_\_\_ No \_\_\_\_ If yes, how much? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you subject to prolonged bleeding? Yes \_\_\_ No \_\_\_

Are you allergic to: Penicillin \_\_\_ Sulfa \_\_\_ Iodine \_\_\_ Novocaine \_\_\_ Adhesive Tape \_\_\_ Other \_\_\_

What medications are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # ( )\_\_\_\_\_\_\_\_\_\_\_\_

Podiatrist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # ( )\_\_\_\_\_\_\_\_\_\_\_\_

*I hereby give my permission to Drs. Adelstein, Goldkind and Hussain to administer treatment and to perform such procedures as they may deem necessary in the diagnosis and/or treatment of my foot or ankle condition. I certify that the above information is correct and true to the best of my knowledge.*

**Patient Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(parent or guardian ) Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please print)

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that all communications to me (by telephone, mail or otherwise) by *Northwest Suburban Foot & Ankle Clinic* and/or its staff be handled in the following manner:

For written communications, address to:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For oral communications, call:

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message? Yes □ No □

Should the need arise, whom may we speak with regarding your medical care?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Telephone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**ACKNOWLEDGEMENT 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.

Signature of Patient or Authorized Representative (if applicable) Date

www.nwfeet.com

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Patient’s or Authorized Signature

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment below:

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s or Authorized Person’s Signature

I authorize payment of medical benefits to the undersigned physician or supplier for services described:

Signed: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Steven T. Adelstein, DPM**

**Adam D. Goldkind, DPM**

**Syed A. Hussain, DPM**

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