



**MARIA CHON, D.P.M.**  
**FAMILY FOOT CARE OF PALATINE**  
 317 E. Dundee Road  
 Palatine, IL 60074  
 Telephone: (847) 359-1600  
 Fax: (847) 359-6484  
 www.palatinepodiatrycenter.com

DATE: \_\_\_/\_\_\_/\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_ SEX: M F  
LAST FIRST MI

HOME ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**MAY WE LEAVE A MESSAGE?**

HOME PHONE #: (\_\_\_) \_\_\_-\_\_\_ YES NO

ALTERNATE PHONE #: (\_\_\_) \_\_\_-\_\_\_ YES NO

E-MAIL: \_\_\_\_\_ YES NO

PRIMARY LANGUAGE: \_\_\_\_\_

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: (\_\_\_) \_\_\_-\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: (\_\_\_) \_\_\_-\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_ WHO REFERRED YOU TO US? \_\_\_\_\_

PHARMACY: \_\_\_\_\_ LOCATION: \_\_\_\_\_ PHONE #: (\_\_\_) \_\_\_-\_\_\_

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

\_\_\_ YES NAME(S) \_\_\_\_\_

\_\_\_ NO

WHO IS RESPONSIBLE FOR PAYMENT? \_\_\_\_\_ RELATIONSHIP TO PATIENT? \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_) \_\_\_-\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_) \_\_\_-\_\_\_

INSURED NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

CONTRACT # \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: (\_\_\_) \_\_\_-\_\_\_

INSURED NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

CONTRACT # \_\_\_\_\_ GROUP # \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SOCIAL HISTORY**

MARITAL STATUS:  SINGLE  MARRIED  PARTNERED  SEPARATED  DIVORCED  WIDOWED

USE OF ALCOHOL:  NEVER  NO LONGER USE  HISTORY OF ALCOHOL ABUSE

CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

USE OF TOBACCO:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_  SMOKE \_\_\_\_\_ PACKS/DAY FOR \_\_\_\_\_ YEARS

USE OF RECREATIONAL DRUGS:  NEVER  QUIT - HOW LONG AGO? \_\_\_\_\_ TYPE \_\_\_\_\_

CURRENT USE - TYPE \_\_\_\_\_  RARE  OCCASIONAL  MODERATE  DAILY

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

HOW MUCH ARE YOU ON YOUR FEET AT WORK?  10%  25%  50%  75%  100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE?  CHILDREN-AGE(S) \_\_\_\_\_  PET(S)-WHAT KIND? \_\_\_\_\_

ELDERLY OR DISABLED FAMILY MEMBER  OTHER \_\_\_\_\_

EXERCISE:  NEVER  RARE  OCCASIONAL  WEEKLY  SEVERAL TIMES A WEEK  DAILY

TYPES OF EXERCISE: \_\_\_\_\_

**FAMILY HISTORY**

DO YOU HAVE A FAMILY HISTORY OF:  DIABETES  CANCER  HEART DISEASE  HIGH BLOOD PRESSURE

STROKE  CORONARY ARTERY DISEASE  THYROID DISEASE  RHEUMATOID ARTHRITIS

OTHER \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_ / \_\_\_ / \_\_\_

**YOUR MEDICAL HISTORY**

ALLERGIES:  NONE KNOWN  MEDICATIONS \_\_\_\_\_

ANESTHESIA \_\_\_\_\_  FOODS \_\_\_\_\_

TAPE  LATEX  SHELLFISH  IODINE  OTHER \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

OTHER CONDITIONS: \_\_\_\_\_

**CURRENT PROBLEM**

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? \_\_\_\_\_

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

**LEFT FOOT**



TOP OF FOOT



BOTTOM OF FOOT



INSIDE OF FOOT



OUTSIDE OF FOOT

**RIGHT FOOT**



BOTTOM OF FOOT



TOP OF FOOT



OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

HOW LONG AGO DID THIS PROBLEM FIRST START? \_\_\_\_\_ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM:  BEGIN ALL OF A SUDDEN  GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN?  NO PAIN  SHARP  DULL  ACHING  BURNING  
 RADIATING  ITCHING  STABBING  OTHER \_\_\_\_\_

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT:  STAYED THE SAME  BECOME WORSE  IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE?  WALKING  STANDING  DAILY ACTIVITIES  
 RESTING  DRESS SHOES  HIGH HEELS  FLAT SHOES  ANY CLOSED TOE SHOE  
 RUNNING  OTHER \_\_\_\_\_

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? \_\_\_\_\_

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? \_\_\_\_\_

WAS THIS PROBLEM CAUSED BY AN INJURY?  YES (DESCRIBE) \_\_\_\_\_  NO

IF YES, WAS IT A WORK-RELATED INJURY?  YES  NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

\_\_\_\_\_  
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
SIGNATURE OF DOCTOR

\_\_\_\_\_  
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



## Consent for Care and Treatment

I, the undersigned do hereby agree to give my consent for the practice of Maria Chon DPM, to furnish foot and ankle services considered necessary and proper in diagnosing and treating my condition.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## Benefit Assignment and Release of Information

I, the undersigned, do hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and third party insurance payers to Maria Chon DPM. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including x-ray records, to secure payment.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## Financial Policy Statement

We will bill your insurance carrier as a courtesy to you. You are responsible for the entire bill. We require that arrangements for payment of your estimated share be made at time service is rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. I also understand and agree to pay for services deemed "not covered services" necessary for the diagnosis and treatment of my foot and ankle condition.

I understand that I will be responsible for any deductibles, co-pays and co-insurances.

If any payment is made directly to you for services billed, you will promptly remit the payment to Maria Chon DPM.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If an appointment is cancelled without at least 24 hours notice, a \$40 fee will be charged.

I have read the above information and understand my responsibility for the payment of my account.

Patient/Guardian/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_



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RECEIPT OF NOTICE OF  
PRIVACY PRACTICES FORM

I, \_\_\_\_\_, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

If you are not the patient, please specify your relationship to the patient.

\_\_\_\_\_