Elyria Foot Clinic & North Coast Surgery Center
Dr. George Costaras, D.P.M.
1170 East Broad Street #104
Elyria, Ohio 44035
440.366.6029

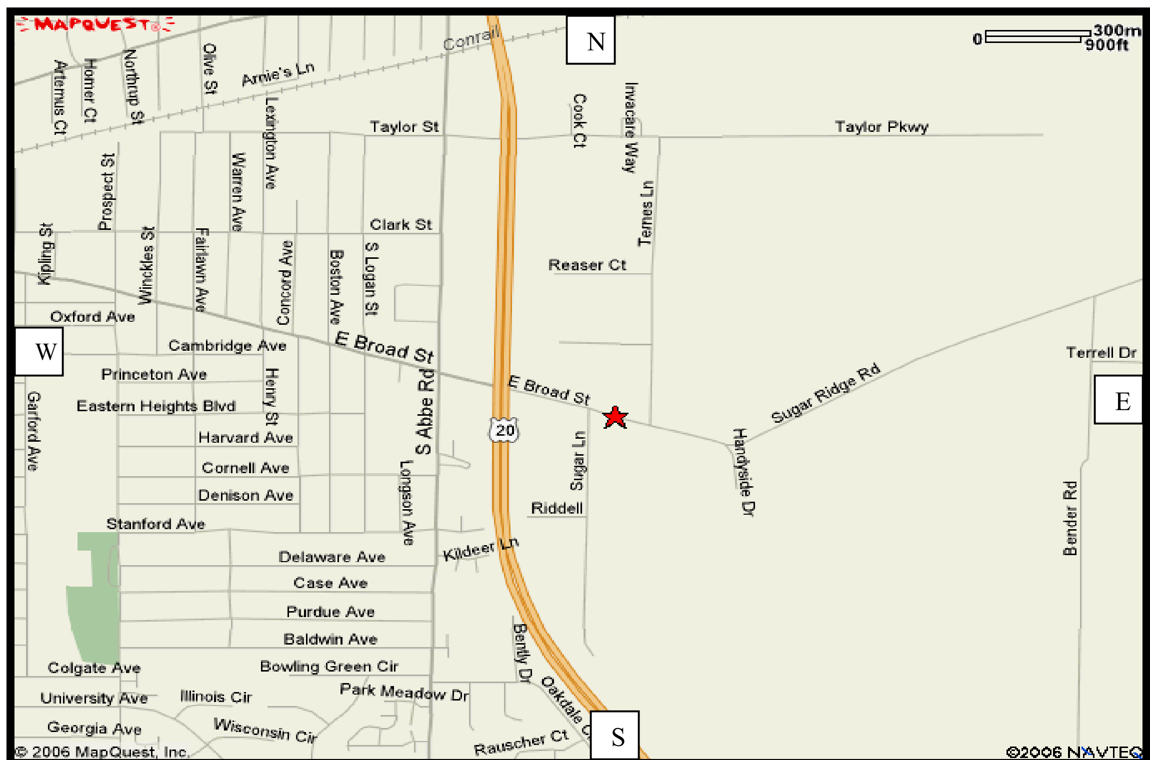
PLEASE COMPLETE THESE FORMS AND BRING WITH YOU TO YOUR APPOINTMENT ON:

____

Also, please bring the following with you:

1. Picture ID (in the case of a minor, we will need parental ID)
2. Medical insurance card(s)
3. A list of all medications the patient is taking (including over-the-counter drugs)

Below is a map to our office. We are located about 500 yards east of Route 57 on the left side of East Broad Street, directly across the street from the 24-hour Quik Wash. We are located in the Heritage Pointe Professional Building in the corner office, Suite 104, of the "L" shaped building.



- All children under 18 must be accompanied by an adult

- If you cannot keep your appointment, please contact us at least 24 hours before your appointment. This allows us to utilize your time slot and reschedule you in a timely manner.

- Please be aware that there is a $20.00 fee for no-show/no-call.

- If you have further questions, please contact us at the above phone number.

Thank You

Dr. George Costaras, D.P.M.

1170 East Broad Street, Suite 104
Elyria, Ohio 44035

CONFIDENTIAL PATIENT REGISTRATION

NAME: ______________________ DATE: ________

BIRTHDATE: ________ SS#: ______________ Male / Female (CIRCLE ONE)

ADDRESS: ______________________________________
CITY STATE ZIP

HOME PHONE: ( ) __________ CELL PHONE: ( ) __________ (OR OTHER NUMBER WHERE WE CAN REACH YOU)

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED OCCUPATION: __________

EMPLOYER: ______________________________ ( ) ________
NAME ADDRESS PHONE

REASON FOR YOUR VISIT TODAY: ______________________________

FAMILY PHYSICIAN: ______________ ADDRESS: ______________

PHONE: ( ) __________ DID YOUR DOCTOR REFER YOU TO US? YES NO

RESPONSIBLE PARTY INFORMATION

(IF DIFFERENT FROM PATIENT, PLEASE SPECIFY. IF SAME, WRITE "SAME")

NAME: ______________ ADDRESS: ______________

PHONE: ( ) __________ RELATIONSHIP: ______________

SS#: __________ BIRTHDATE: ______________

EMPLOYER: ______________________________ ( ) ________
NAME ADDRESS PHONE

MEDICAL INSURANCE INFORMATION

(PLEASE NOTE: YOU DO NOT NEED TO PUT ID/GRP # IF WE HAVE A COPY OF YOUR INSURANCE CARD)

PRIMARY INS.: ______________ ID/GROUP #: ______________

SECONDARY INS.: ______________ ID/GROUP #: ______________

GENERAL INFORMATION

HOW DID YOU HEAR ABOUT US? ______________________________

If we need to contact you, may we call you at the numbers given for home, cell, or work and leave a message on your answering machine/voice mail or with the adult answering the phone? ☐ YES ☐ NO

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: ______________ DATE: ________

PLEASE BE SURE TO COMPLETE BACKSIDE OF FORM

MEDICAL HISTORY

AGE: ____________ **HEIGHT:** ____________ **WEIGHT:** ____________

MEDICATION(S)

PLEASE LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER & HERBAL YOU ARE CURRENTLY TAKING

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

ALLERGIES

PLEASE LIST ALL DRUG ALLERGIES AND YOUR REACTION

1) ____________ **3)** ____________

2) ____________ **4)** ____________

HOSPITALIZATIONS/PAST SURGERIES (PLEASE INCLUDE ALL PAST PROCEDURES)

PROCEDURE	DATE	PLACE	REASON FOR PROCEDURE

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

RASH	☐ Yes	☐ No	**HIGH ARCHES**	☐ Yes	☐ No	**ARCH PAIN**	☐ Yes	☐ No
BUNIONS	☐ Yes	☐ No	**HEEL PAIN/SPURS**	☐ Yes	☐ No	**FLAT FEET**	☐ Yes	☐ No
CORNS	☐ Yes	☐ No	**FOOT BREAK/SPRAIN**	☐ Yes	☐ No	**LEG PAIN**	☐ Yes	☐ No
CALLUSES	☐ Yes	☐ No	**ANKLE BREAK/SPRAIN**	☐ Yes	☐ No	**HAMMERTOE**	☐ Yes	☐ No
WARTS	☐ Yes	☐ No	**INGROWN TOENAILS**	☐ Yes	☐ No	**NEUROMA**	☐ Yes	☐ No
INTOEING	☐ Yes	☐ No	**DIABETIC NEUROPATHY**	☐ Yes	☐ No	**FOOT ULCER**	☐ Yes	☐ No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

ALZHEIMER'S DISEASE	☐ Yes	☐ No	**HIGH CHOLESTEROL**	☐ Yes	☐ No
ANEMIA	☐ Yes	☐ No	**HYPERTHYROIDISM**	☐ Yes	☐ No
ARTHRITIS	☐ Yes	☐ No	**HYPOTHYROIDISM**	☐ Yes	☐ No
BLEEDING DISORDER	☐ Yes	☐ No	**KIDNEY DISEASE**	☐ Yes	☐ No
CHEST PAIN	☐ Yes	☐ No	**LIVER DISEASE**	☐ Yes	☐ No
CIRCULATION PROBLEMS	☐ Yes	☐ No	**LUNG DISEASE**	☐ Yes	☐ No
DEMENTIA	☐ Yes	☐ No	**NERVOUS SYSTEM PROBLEMS**	☐ Yes	☐ No
DEPRESSION	☐ Yes	☐ No	**NUMBNESS/CRAMPS IN FEET OR LEGS**	☐ Yes	☐ No
DIABETES	☐ Yes	☐ No	**PACEMAKER**	☐ Yes	☐ No
DOUBLE JOINTED	☐ Yes	☐ No	**POOR VISION**	☐ Yes	☐ No
EPILIPSY	☐ Yes	☐ No	**PSYCHIATRIC CONDITION**	☐ Yes	☐ No
FAINTING SPELLS	☐ Yes	☐ No	**RECENT WEIGHT LOSS OR GAIN**	☐ Yes	☐ No
GALL BLADDER DISEASE	☐ Yes	☐ No	**SHORTNESS OF BREATH**	☐ Yes	☐ No
GLAUCOMA	☐ Yes	☐ No	**SICKLE CELL ANEMIA**	☐ Yes	☐ No
HEARING PROBLEMS	☐ Yes	☐ No	**SKIN DISORDER**	☐ Yes	☐ No
HEART DISEASE	☐ Yes	☐ No	**STOMACH DISORDER**	☐ Yes	☐ No
HEART STENT(S)	☐ Yes	☐ No	**STOMACH ULCER**	☐ Yes	☐ No
HEPATITIS	A B	C	**STROKE OR TIA**	☐ Yes	☐ No
HIGH BLOOD PRESSURE	☐ Yes	☐ No	**SWELLING OF FEET OR ANKLES**	☐ Yes	☐ No

SOCIAL HISTORY

ALCOHOLISM	☐ Yes	☐ No	**VENERAL DISEASE**	☐ Yes	☐ No
DRUG ADDICTION	☐ Yes	☐ No	**EXPLAIN:** ____________		
DO YOU SMOKE	☐ Yes	☐ No	**ARE YOU PREGNANT?**	☐ Yes	☐ No

AUTHORIZATION FORM
ELYRIA FOOT CLINIC INC./NORTH COAST SURGERY CENTER, L.L.C.

A. Consent to Treatment
   I consent to treatment by Dr. George Costaras of the Elyria Foot Clinic and/or North Coast Surgery and its employees. I understand that this care may include tests, examinations, and medical and surgical treatment as discussed with Dr. Costaras.

B. Consent to Release Medical Information
   I hereby authorize the clinic to disclose all or any part of my medical care information to (A) any person or entity that may be liable for payment of charges associated with my medical care, including but not limited to, hospitals, insurance companies, governmental payers such as Medicare or Medicaid, workers' compensation carriers, and welfare funds; (B) any person or facility that is currently involved in my care, such as physicians and nurses, and any facility that may be involved in the continuum of my care, such as a nursing home, home health agency, or durable medical equipment provider; (C) my employer if my injury is work-related; (D) any person or entity that may process or collect a claim for payment, such as a billing company or collection agency and (E) family members or relatives involved in my care.

C. Assignment of Insurance Benefits
   I hereby assign to Elyria Foot Clinic/North Coast Surgery Center, LLC., and/or Dr. George Costaras, any and all benefits, including major medical, that are payable to the patient or the undersigned for payment of medical care and treatment. Should the account be referred to any attorney or collection agency for collection, the undersigned shall be responsible for any reasonable attorney's fees and collection expense in addition to the amount being collected.

D. Insurance Coverage
   I understand that I am financially responsible for any and all charges not covered by my insurance company due to plan deductibles/co-insurance amounts and/or any excluded services under my plan. I also understand that it is my sole responsibility to know my plan coverage before any services are rendered.

E. Appointments
   I understand that if I am more than 15 minutes late for my appointment time, it will be rescheduled for a later date and time. In the event I cannot make it to a scheduled appointment, I understand it is my responsibility to cancel it 24 hours prior to my appointed time. If I do not cancel my appointment or do not show up for my appointment, I understand that I will be assessed a $20.00 no show fee for regular office visits and/or a $100.00 no show fee for scheduled procedures or surgeries.

F. Notice of Privacy Practices
   I acknowledge that I was provided a copy of Notice of Privacy Practices and have had the opportunity to read the Notice.

My signature below certifies I have read and understand the contents of this Authorization Form and that any questions I had were clarified for me before I signed it.

Signature: ______________________________ Patient or legal representative Date: _________________

ELYRIA FOOT CLINIC
DR. GEORGE COSTARAS
1170 East Broad Street #104
Elyria, OH 44035
440.366.6029
440.366.6064 (FAX)

AUTHORIZATION FOR EXAMINATION AND TREATMENT OF A MINOR PATIENT

NAME:____ **AGE:**____________________

I hereby authorize Dr. George Costaras and whomever he may designate as his assistant(s) to perform a podiatric examination and institute the appropriate treatment upon the above-named minor, who is in my personal custody in the relationship of my ________________________.

I understand that the Doctor may require x-rays and/or blood studies in order to make a proper diagnosis; and that medication(s), injections(s), physical therapy, casting(s), and/or surgery may be necessary to properly treat my the above-named minor.

I certify that I have read and fully understand this AUTHORIZATION FOR EXAMINATION AND TREATMENT OF A MINOR.

_______________________________________ ________________________________
Signature of Parent or Guardian Date