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

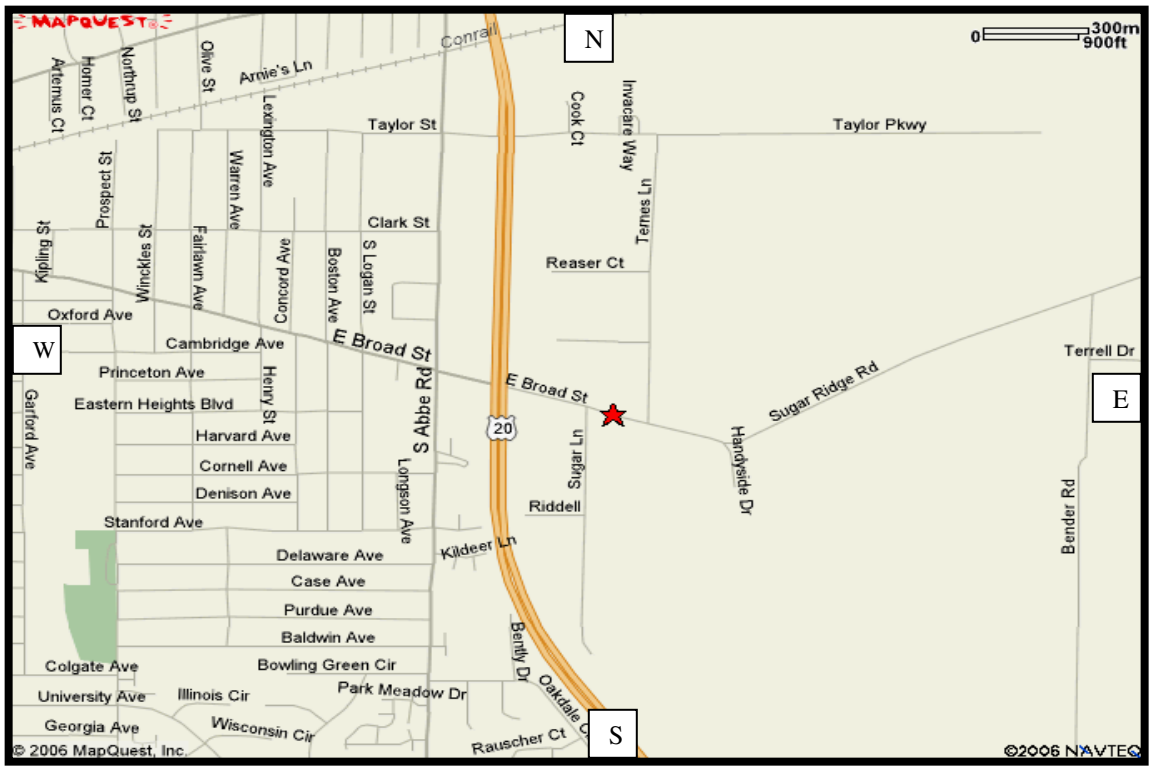
PLEASE COMPLETE BOTH SIDES OF THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT ON:

_____

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

ELYRIA FOOT CLINIC, INC & NORTH COAST SURGERY CENTER, LLC.

Podiatry Patient Information

Date……

Name……

Date of Birth……Age……

Height……Weight……Male ☐ Female ☐

Email Address……

Address……

City,……State……Zip …….

Home Phone……Cell ……Work……

Referred by……

Primary Care Doctor……

Pharmacy Name……

Pharmacy Location……

Emergency Contact……

Emergency Phone……

Legal Guardian?……

Patient Insurance Information

Primary Insurance……

Secondary Insurance……

Patient SS#……

Responsible Payor……

Patient Medical Information

Describe Foot/Ankle Problem:

……

……

……

……

How long ago did problem start?

……

Did your pain……

☐ Begin Suddenly ☐ Over Time

Describe Pain……

☐ None ☐ Sharp ☐ Stabbing ☐ Burning

☐ Aching ☐ Itching ☐ Radiating ☐ Dull

Rate your pain on a 1-10 scale…….

None.. 1..2..3..4..5..6..7..8..9..10..Worst

What makes pain/problem worse?

……

……

……

Was problem caused by an injury?

☐ No ☐ Yes

Was this a work related injury?

☐ No ☐ Yes

What treatments have you tried?

……

……

Social History:

Alcohol Use…….. ☐ No ☐ Yes

☐ Rare ☐ Social ☐ Moderate ☐ Daily

History of Abuse…… ☐ No ☐ Yes

Tobacco Use…….. ☐ No ☐ Yes

☐ Quit/When……

……Packs/Day for……Years

Recreational Drugs……

☐ Never ☐ Quit/When……

☐ Currently Use Type……

Marital Status……

☐ Single ☐ Married ☐ Separated

☐ Partnered ☐ Divorced ☐ Widowed

Are You Pregnant….. ☐ No ☐ Yes

Employer……

Occupation……

How much are you on your feet daily?

☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others depend on you for care?

☐ No ☐ Yes

Do you exercise?

☐ Never ☐ Occasionally ☐ Weekly

☐ Several times a week ☐ Daily

Type of exercise……

……

Medications:

(Prescriptions,Over-the Counter and Herbal Supplements)

……

……

……

……

……

……

……

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……

……

……

Allergies:

☐ None Known

☐ Sulfa ☐ Penicillin

☐ Codine ☐ Aspirin ☐ Tape

☐ Other Medications ……

……

☐ Other……

……

Patient Medical History

Check Any Conditions You Have Ever Experienced

- ☐ Alzheimer's/Dementia
- ☐ Acid Reflux/GERD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bladder Infections
- ☐ Abnormal Bleeding
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Bronchitis/Emphysema/COPD
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilespy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease/Failure
- ☐ Heart Stents
- ☐ Hepatitus
- ☐ HIV+/AIDS
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Nervous System Problems
- ☐ Neuropathy
- ☐ Numb/Cramps In Feet
- ☐ Open Sores
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Skin Disorder
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis

General Health Issues

Do your feet hurt at night?	Y / N
Do you have trouble walking?	Y / N
Do you get leg cramps?	Y / N
Pain in legs when walking?	Y / N
Does rest relieve pain?	Y / N
Do you have vascular grafts?	Y / N
Replacement heart valves?	Y / N
Undergoing chemotherapy?	Y / N
Have you needed medical care at home?	Y / N

List All Prior Surgeries

Type	Date
……	
……	
……	
……	

List All Prior Hospitalizations

……

……

……

……

Family Medical History

Check Any Family History and Write Relationship

- ☐ Cancer…… ☐ Heart Disease…… ☐ Stroke……..
- ☐ Coronary Artery Disease…… ☐ High Blood Pressure…… ☐ Thyroid Disease……
- ☐ Diabetes…… ☐ Rheumatoid Arthritis…… ☐ Other……

Patient Acknowledgement of Responsibility:

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 — Date

…….. ……..

If Other Than Patient, Relationship To Patient — Signature

CONSENT AND AUTHORIZATION

This consent is required by the Health Insurance Portability and Accountability Act of 1996

1. **Consent for care:** I, with my signature, authorize treatment by Dr. George Costaras, Elyria Foot Clinic Inc and/or North Coast Surgery Center, LLC and any employee working under the direction of the physician, to provide medical care for me, or to this patient for whom I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and my include (but limited to) preventive, diagnostic, palliative care, counseling, surgical, dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.
2. **Consent for release of information:** I also authorize this practice to furnish information of the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Medical Privacy Notice.
3. **Consent for assignment of benefits:** I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and any co-insurance amounts, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. I understand that, ultimately, I am responsible for fees associated with my treatment
4. **Consent for late fees:** I understand that any balance that is not covered by my insurance will be billed to me directly. If I fail to make payment during any billed month, I agree to a $10 per month late fee. I understand that after 3 months of non-payment, I will be sent to a collection agency and my credit will be negatively impacted.
5. **Consent and acknowledgement of Medical Privacy Notice:** I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions.
6. **Consent for Laboratory Services:** I understand that any specimens that are collected during my visit may be sent to BAKO PATHOLOGY SERVICES or other labs. I also understand that I may receive a separate bill from other lab(s) for any specimens sent for evaluation. It is my responsibility to know if this lab is covered by my insurance plan.
7. **Consent for negligence fees:** I understand that appointments must to be cancelled 24 hours prior to my scheduled time. If I fail to cancel an appointment, I am responsible for a **$20.00** no show fee that is not covered by insurance. Additionally, I understand that surgeries must be cancelled 3 days prior to my scheduled appointment or I am responsible for a **$100.00** service and preparation fee, which is not covered by my insurance. I understand that if any check that I have submitted for payment is returned for insufficient funds, I will be responsible for a **$45.00** fee.

I understand that this practice may refuse me services if I refuse to sign this consent.
Patient/Guardian Signature: _____Date: _____

Name Printed: _____ If not patient, relationship: _____

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North Coast Surgery Center, LLC
Dr. George Costaras
1170 E. 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, Elyria Foot Clinic, Inc., North Coast Surgery Center, LLC and whomever designated as an assistant 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 x-rays and/or blood studies may be needed 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

_____
Printed Name of Parent or Guardian