MITCHELL
FOOT & ANKLE, P.C.

PATIENT INFORMATION

Patient's Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt_____ Age_____
City_____ State_____ Zip_____ Marital Status_____
SS#_____ Email_____

Home Ph#____(____)_____
Cell Ph#____(____)_____ Best number to contact you: Shoe Size_____
Work Ph#____(____)_____ ☐ Home ☐ Cell ☐ Work

Employer_____ Occupation_____
Primary Insurance_____ Secondary Insurance_____
Primary Insured_____ Primary Insured_____
Primary Insured's DOB_____ Primary Insured's DOB_____
ID#_____ ID#_____
Group#_____ Group#_____
Primary Care Physician (PCP)_____ PCP Ph#_____
Date of Last PCP Visit_____
Hospital_____
Name & Ph# of any other treating doctors_____
_____

Who should we thank for referring you?_____
Emergency Contact_____ Relationship_____
Emergency Contact Ph#_____

REASON FOR VISIT

Please describe your foot/ankle problem_____
_____
_____
_____

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 understand the notice.

I have received information on the Education and Training of Dr. Mitchell.

I, also, authorize Mitchell Foot & Ankle, PC to release any of my chart information to the following person(s): ie spouse, mother, father, guardian, other relatives, etc. Please print name below:

_____ _____ _____

Patient's Signature_____

ASSIGNMENT AND RELEASE

I hereby give permission to Dr. Mitchell and his associates/staff to administer treatment, as necessary, for the diagnosis and/or treatment of my foot/ankle condition.

I hereby authorize payment directly to Mitchell Foot & Ankle PC for services rendered by Dr. Mitchell and his associates/staff. I understand and acknowledge that I am financially responsible for the entire services provided for myself or the above names, regardless of insurance coverage.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ **Date**_____

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HISTORY – Personal - Social – Family – Medical - Surgical

Patient's Name_____ Date of Birth_____

If appropriate, Name & phone # of Legally Responsible Person:_____

Special considerations due to cultural or religious beliefs: ☐ No ☐ Yes, specify_____

Language: ☐ English ☐ Spanish ☐ Other_____ ☐ Translator needed

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
☐ Caucasian ☐ Other_____ ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Limitations: ☐ None ☐ Hearing ☐ Vision ☐ Cognitive Impaired ☐ Mobility ☐ Illiterate

Social History

Smoking: ☐ No, Never ☐ Quit, as of_____
☐ Yes – Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing tobacco/snuff - __ # packs/ea Per day – week

Alcohol: ☐ No ☐ Yes – Type:_____ Frequency: _____/ day / week; ☐ Occasional

Recreational Drug Use/Abuse: ☐ Denies Use ☐ Admits Occasional Use

Exercise: ☐ Not Regularly ☐ Walking ☐ Treadmill ☐ Aerobics ☐ Golf/TennisJogging ☐ Weight Lifting
☐ Other_____

Caffeine: ☐ No ☐ Yes – Amount/day_____ Type_____

Family History

	Living	Deceased	Explanation
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Children- # of_____			

ALLERGIES

☐ No Known Allergies ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Latex ☐ Aspirin

☐ Food, specify_____

☐ Other_____

MEDICAL DIAGNOSIS & CONDITIONS

☐ No Known Conditions ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Anemia ☐ Arthritis ☐ Back ☐ Bowel

☐ Cancer, Type_____ ☐ Circulation ☐ Heart Attack ☐ Hepatitis ☐ Kidney/Bladder

☐ Seizure ☐ Stomach ☐ Stroke ☐ Thyroid ☐ Aids/HIV Other_____

SIGNIFICANT SURGICAL & INVASIVE PROCEDURES

Date	Description

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Patient's Name_____ Date of Birth_____

Emergency Contact_____ Ph#_____

MEDICATION LIST

Date	Medication, Herbals, Vitamins, Over-the-counter drugs	Strength	Dose	Frequency
	(For example: Lipitor)	*(10 mg)*	*(1 tab)*	*(1 x / day)*

At each visit, please verify and update current prescriptions, OTC, herbals and vitamins.

Disclaimer: This list is provided to you by this facility as an education tool. We have noted all the medications you are currently taking, including the medication(s) we have prescribed. This list is prepared based on the information you have provided us. This facility is not responsible to maintain, prescribe or refill any of the above medication(s).

YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

Chicago Surgicare/Mitchell Foot & Ankle, P.C.
1424 E. 53rd Street, Suite 301, Chicago, Illinois 60615
Phone: 773-324-3338 Fax: 773-324-1866
This is a physician owned facility

PATIENT RIGHTS

Respect and Dignity
You have the right to be treated with consideration, respect and dignity, acknowledging your individuality and the values that affect your response to care.

Privacy
You have the right to expect that all those involved in your care will honor your right to privacy and ensure the privacy of your care and medical record.

Identity
You have the right to know the names, positions and professional relationships of all individuals involved in your care.

Information
You have the right to expect to receive sufficient information, in terms you understand, regarding your diagnosis, treatment prognosis and follow-up care. *(In the event that your health makes it inadvisable to give you such information, the information will be provided to a person designated by you or a legally authorized person.)*

Participate in Care Decisions
You have the right to participate in the decisions affecting your health care in collaboration with your physician, except when such participation is not indicated for medical reasons.

Refusal of Treatment
You have the right to accept medical care or refuse treatment within the limits of the law and to be informed of the consequences of refusal.

Assessment of Pain
You have the right to appropriate assessment and management of pain.

Access to Medical Record
You have the right to inspect and obtain a copy of your medical record and to expect a reasonable and timely transfer of information from one physician to another.

Knowledge of Financial Obligations
You have the right to information regarding your bill prior to treatment and to examine and receive an explanation of your bill regardless of the source of payment.

Resolution of Patient Complaints
You have the right to expect that Chicago Surgicare/Mitchell Foot & Ankle, P.C. will try to resolve all patient complaints without compromising your future access to care.

PATIENT RESPONSIBILITIES

Providing Information
You are responsible for providing, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications and other matters relating to your health. You are responsible for reporting any perceived risks regarding your care and reporting unexpected changes in your condition.

Asking Questions
You are responsible for making known whether you clearly comprehend your diagnosis, treatment and follow-up care plan and what is expected of you.

Participation
You are responsible to fully participate in decisions involving your health care and to accept the consequences of those decisions if complications occur.

Following Instructions
You are responsible for following the treatment plan recommended by your physician. You should express your concerns regarding your inability to comply with a planned course of treatment and in understanding the consequences of any treatment alternatives.

Accepting Consequences
You are responsible for your actions if you refuse treatment or do not follow the physician's instructions.

Following Rules and Regulations
You are responsible for keeping your appointment, or cancelling 24 hours prior to your scheduled appointment, helping control noise and disturbances, following the no smoking policy and respecting other's property.

Meeting Financial Commitments
You are responsible for assuring that the financial obligations for your health care are fulfilled as promptly as possible.

Respect and Consideration
You are responsible for being considerate and respectful of the rights of others.

ADVANCED DIRECTIVE
In the event of an emergency, 911 will be called. If you have executed an Advanced Directive, please bring it or a copy to our office and we will place it in your medical chart.

MISSION

Chicago Surgicare/Mitchell Foot & Ankle, P.C. is dedicated to providing a high level of care to patients of all ages in an atmosphere that encourages patient involvement. Our medical and surgical care is limited to the specialty of Podiatric Medicine and Surgery, which includes complete care of the foot and ankle.

Chuck Mitchell, D.P.M.
Dr. Mitchell studied podiatric medicine at the Dr. William M. Scholl College of Podiatric Medicine in Chicago. He completed two surgical residency programs. A one year program at Sinai Hospital of Baltimore in Maryland and a two year program at Edgewater Hospital in Chicago.

Office Hours

Monday & Tuesday:	10:00 am - 5:00 pm	Friday:	10:00 am – 2:00 pm; Surgery by appointment
Wednesday:	12:00 pm - 7:00 pm	Saturday:	(Every other) 10:00 am – 2:00 pm
Thursday:	9:00 am – 5:00 pm		

After Hours
If you need to reach a doctor after hours, please call our office for paging instructions and the doctor will call you back.

YOU ARE A PARTNER IN THE HEALTH CARE PROCESS!

Your involvement in helping us deliver quality health care is important. Please share your concerns and comments with us. Should you have a concern regarding quality of care or a safety issue, we would appreciate it if you would bring it to the attention of our Office Manager. You have the right to expect that the Chicago Surgicare/Mitchell Foot & Ankle, P.C. will try to resolve all of your concerns without compromising your future access to care. We are committed to providing the highest level of care. Anyone believing that they have pertinent and valid information about quality of care issues or the safety of our environment that we have not addressed, may contact:

The Joint Commission at 1-800-994-6610 or visit www.jointcommission.org and click on "report a complaint."