

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.

PATIENT INFORMATION FORM

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____ Male / Female
(CIRCLE ONE)

ADDRESS: _____
CITY STATE ZIP

MAY WE LEAVE A MESSAGE? _____ SS# _____

HOME PHONE: () _____ YES NO EMAIL ADDRESS: _____

WORK PHONE: () _____ YES NO _____

CELL PHONE: () _____ 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 US TO SHARE YOUR MEDICAL INFORMATION?
 NO YES NAME(S) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ DATE OF BIRTH: _____ EMPLOYER: _____

SECONDARY INSURANCE COMP. NAME: _____

INSURED NAME: _____ DATE OF BIRTH: _____ EMPLOYER: _____

MEDICATIONS

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

NAME	DOSE	HOW OFTEN DO YOU TAKE?

*****ALLERGIES** NONE KNOWN MEDICATIONS: _____
 ANESTHESIA TAPE LATEX SHELLFISH IODINE
 OTHER _____

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 PER DAY? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE (INCLUDE FAMILY &/OR PETS)? NO YES

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: _____

YOUR MEDICAL HISTORY

ALZHEIMER'S/DEMENTIA	Y N	EPILEPSY	Y N	NERVOUS SYS. PROBLEMS	Y N
ACID REFLUX	Y N	FIBROMYALGIA	Y N	NEUROPATHY	Y N
ANEMIA	Y N	GOUT	Y N	NUMB/CRAMPS IN FEET	Y N
ARTHRITIS	Y N	HEART ATTACK	Y N	OPEN SORES	Y N
ASTHMA	Y N	HEART DISEASE/FAILURE	Y N	PACEMAKER	Y N
BACK TROUBLE	Y N	HEART STENT(S)	Y N	PNEUMONIA	Y N
BLADDER INFECTIONS	Y N	HEPATITIS	Y N	POLIO	Y N
ABNORMAL BLEEDING	Y N	HIV+/AIDS	Y N	RHEUMATIC FEVER	Y N
BLOOD CLOTS	Y N	HIGH BLOOD PRESSURE	Y N	SICKLE CELL DISEASE	Y N
BLOOD TRANSFUSION	Y N	HIGH CHOLESTEROL	Y N	SKIN DISORDER	Y N
BRONCHITIS/EMPHYSEMA	Y N	KIDNEY DISEASE	Y N	SLEEP APNEA	Y N
CANCER	Y N	LIVER DISEASE	Y N	STOMACH ULCERS	Y N
DEMENTIA	Y N	LOW BLOOD PRESSURE	Y N	STROKE	Y N
DEPRESSION	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? _____

HOW LONG AGO DID THIS PROBLEM 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? NO YES (PLEASE DESCRIBE BELOW)

WAS THIS 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

DATE

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

SIGNATURE

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

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. Laboratory Services

I understand that any and all specimens that are collected during my visit are sent to **BAKO PATHOLOGY SERVICES**. I also understand I will be receiving a separate bill from this lab for any specimens sent to them. It is my responsibility to know if this lab is covered under my insurance plan. If I do not wish to have my lab work sent to this lab, I will inform the staff prior to the specimen collection.

C. 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.

D. 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.

E. 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.

F. 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 call and cancel prior to my appointed time. If I do not show up to my scheduled appointment without calling to cancel, 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.**

G. 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.

Print Name: _____

Signature: _____ Patient or legal representative Date: _____