

# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Marital Status  Single  Married  Widowed  
 Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_

Email \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship \_\_\_\_\_ Date \_\_\_\_\_

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date

**PODIATRIC HISTORY**

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints)

Have you ever been to a Podiatrist before?  Yes  No

If yes, please list.

Name \_\_\_\_\_

Last Visit \_\_\_\_\_

Is there any personal or family history of diabetes?  Yes  No

Your occupation \_\_\_\_\_

Cigarette/Tobacco use \_\_\_\_\_

Years smoked \_\_\_\_\_

Athletic activities in which you participate (please list and indicate frequency)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please indicate which foot problems you now have or have had in the past

Ankle Pain  Yes  No

Athlete's Foot  Yes  No

Bunions  Yes  No

Corns and Calluses  Yes  No

Cramps or Numbness in  Yes  No

Feet or legs  Yes  No

Flat Feet  Yes  No

Foot or Leg Cramps  Yes  No

Heel Pain  Yes  No

Ingrown Toenails  Yes  No

Plantar Warts  Yes  No

Swelling in Ankles or Feet  Yes  No

Tired Feet  Yes  No

## MEDICAL HISTORY

Place a mark on "yes" or "No" to indicate if you have had any of the following

AIDS/HIV                     Yes  No

Allergies to Anesthetics

Allergies to Medicine or  
Drugs

Anemia

Angina

Arthritis

Artificial Heart Valves

Of joints

Asthma

Back Problems

Bleeding Disorders

Cancer

Chemical Dependency

Chest Pain

Chronic Diarrhea

Circulatory Problems

Diabetes

Ear Problems

Epilepsy

Eye Problems

Fainting

Foot or Leg Cramps

Gout

Headaches

Heart Disease

Hemophilia

Hepatitis or Jaundice

High Blood Pressure

Kidney Problems

Liver Disease

Low Blood Pressure

Nervous Problems

Phlebitis

Psychiatric Care

Radiation Treatment

Rash

Respiratory Disease

Rheumatic Fever

Shortness of Breath

Sinus Problems

Special Diet

Stroke

Swelling in Ankles, Feet

Swollen Neck Glands

Tired Feet

Tuberculosis

Ulcers

Varicose Veins

Venereal Disease

Weight Loss, unexplained

Surgeries you have had \_\_\_\_\_

Hospitalization other than for the surgeries listed: \_\_\_\_\_

Family Physician \_\_\_\_\_ Last Visit Date \_\_\_\_\_

Are you now, or have you been, under any other doctor's care for any reason over the past two years?  Yes  No

If yes, please explain \_\_\_\_\_

## MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins \_\_\_\_\_

\_\_\_\_\_

Pharmacy Name(s) \_\_\_\_\_

Pharmacy Phone(s) \_\_\_\_\_

Do you take oral contraceptives?  Yes  No

## ALLERGIES

Adhesive/Tape

Anticoagulant

Therapy

Aspirin

Codeine

Demerol

Iodine

Local

Anesthetics

Novocaine

Penicillin

Seafoods

Sulfa

Other \_\_\_\_\_

## CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

**TEXAS FOOT CONSULTANTS**  
**ACKNOWLEDGMENT 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 understood the Notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature