DFW PODIATRY

PATIENT INFORMATION

Date ____________

Patient ____________

Street Address ____________

____
City State Zip

Mailing Address (If different from Street)

____

____
City State Zip

Sex: ☐ M ☐ F Age____ Birthdate ____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # ____________

Driver's License # ____________

Occupation ____________

Employer ____________

Employer Address ____________

Employer Phone ____________

Spouse's Name ____________

Birthdate ____________ SS # ____________

Occupation ____________

Spouse's Employer ____________

Referred by: ☐ Patient ☐ Yellow Pages ☐ Insurance Plan ☐ Doctor ☐ Radio ☐ Website

If referred by Patient, whom may we thank for referring you? ____________

PHONE NUMBERS

Home ____________

Work ____________ Ext ______

Cell Phone ____________

Best time and place to reach you ____________

IN CASE OF EMERGENCY, CONTACT:

Name ____________ Relationship ______

Home Phone ____________

Cell Phone ____________

Work Phone ____________ Ext ______

INSURANCE

Who is responsible for this account? ____________

Relationship to Patient ____________

Primary Insurance Co. ____________

Group # ____________ ID # ____________

Insured's Name ____________

Birthdate ____________ SS # ____________

Insurance Co. Phone ____________

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance Co. ____________

Insured's Name ____________

Birthdate ____________ SS # ____________

Group # ____________ ID # ____________

Insurance Co. Phone ____________

PREFERRED METHOD OF PAYMENT

(check one please) ☐ CASH ☐ CHECK ☐ CREDIT CARD

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________ and assign directly to DFW Podiatry 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 doctors to release all information necessary to service 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 to be made either to me or on my behalf to DFW Podiatry for any services furnished to me by physicians of DFW Podiatry. 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 of 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 release of the information to the insurer or agency shown, in Medicare assigned cases, the physicians or supplier agree to accept the charge determination of the Medicare Carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

____________ ____________
Beneficiary Signature Date

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 ____________

PODIATRIC HISTORY

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

____

____

____

Height ______ Weight ______ Shoe Size ______

How painful is this? ______

What prior treatment have you had?

____

____

Does this interfere with wearing shoes, walking or work?

____

Have you ever been to a Podiatrist before? ☐Yes ☐No

If yes, please list.

Name ______________________

Last Visit ______________________

Cigarette/Tobacco use ☐Yes ☐No

How Much? ______________________

Alcohol consumption ☐Yes ☐No

How much? ______________________

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 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	☐Yes	☐No
Anemia	☐Yes	☐No
Angina	☐Yes	☐No
Arthritis	☐Yes	☐No
Artificial Heart Valves or Joints	☐Yes	☐No
Asthma	☐Yes	☐No
Back Problems	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No
Cancer	☐Yes	☐No
Chemical Dependency	☐Yes	☐No
Chest Pain	☐Yes	☐No
Circulatory Problems	☐Yes	☐No
Diabetes	☐Yes	☐No
Ear Problems	☐Yes	☐No
Epilepsy	☐Yes	☐No
Eye Problems	☐Yes	☐No
Fainting	☐Yes	☐No
Foot or Leg Cramps	☐Yes	☐No
Gastrointestinal Disorders	☐Yes	☐No
Gout	☐Yes	☐No
Headaches	☐Yes	☐No
Heart Disease	☐Yes	☐No
Hemophilia	☐Yes	☐No
Hepatitis or Jaundice	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Kidney Problems	☐Yes	☐No
Liver Disease	☐Yes	☐No
Low Blood Pressure	☐Yes	☐No
Nervous Problems	☐Yes	☐No
Numbness	☐Yes	☐No
Phlebitis	☐Yes	☐No
Psychiatric Care	☐Yes	☐No
Rash	☐Yes	☐No
Respiratory Disease	☐Yes	☐No
Stroke	☐Yes	☐No
Swelling In Ankles, Feet	☐Yes	☐No
Tired Feet	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Varicose Veins	☐Yes	☐No

Other ______________________

FAMILY HISTORY

Please mark on YES or NO to indicate if you have a family history of any of the following:

Diabetes	☐Yes	☐No
Cancer	☐Yes	☐No
Arthritis	☐Yes	☐No
Hypertention	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Hemophilia	☐Yes	☐No
Kidney Disease	☐Yes	☐No
Heart Disease	☐Yes	☐No
Endocrine Disorders	☐Yes	☐No

Other ______________________

____

____

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 care for any reason over the past two years? ☐Yes ☐No

If yes, please explain ______________________

____

TREATMENT CONSENT

I certify that the above information is true and correct to the best of my knowledge. I hereby consent and give my permission to the doctor (and to the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Patient's Signature ______________________ Date ______________________