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