Dora Achille, DPM
Sean Luh, DPM

Flower Mound Office
3208 Long Prairie Road Suite B
Flower Mound, TX 75022
P: (972) 539-8488
F: (972) 874-1107

Bedford Office
2608 Harwood Road
Bedford, TX 76021
P: (817) 283-7288
F: (817) 283-7311

Podiatric History

What is chief complaint? (Include foot, ankle, knee, thigh, and hip complaints)
_____
_____
_____

Pain on a scale from 1 to 10: _____
What prior treatment have you had?: _____
_____
Does this interfere with wearing shoes, walking, or your work?: _____

Height: _____ Weight: _____ Shoe Size: _____

Have you seen a Podiatrist before?: Y / N
If yes, please list
Name: _____
Last Visit: _____

Social History
Cigarette/Tobacco use: Y / N
How much?: _____
Alcohol Consumption: Y / N
How much?: _____
Athletic Activities (activity & frequency)
_____
_____
_____

Please check any foot problems you have or have had in the past.
___Ankle Pain
___Athlete's Foot
___Bunions
___Corns/Calluses
___Cramps or Numbness in Feet/Legs
___Flat Feet
___Heel Pain
___Ingrown Toenails
___Plantar Warts
___Swelling in Ankles/Feet
___Tired Feet

Medical History

Check to indicate if you have/had any of the following:

___ AIDS/HIV
___ Anemia
___ Arthritis
___ Artificial Heart, Valves, or Joints
___ Asthma
___ Back Problems
___ Bleeding Disorders
___ Cancer
___ Chemical Dependency
___ Chest Pain
___ Circulatory Problems
___ Diabetes
___ Ear Problems
___ Epilepsy
___ Eye Problems
___ Fainting
___ Gastrointestinal Disorders
___ Other _____

___ Gout
___ Headaches
___ Heart Disease
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ Jaundice
___Kidney Problems
___ Liver Disease
___ Low Blood Pressure
___ Nervous Problems
___ Psychiatric Care
___ Rash
___ Respiratory Disease
___ Stroke
___ Tuberculosis
___ Varicose Veins

Family History

Check to indicate if you have a family history of any of the following:

___ Diabetes ___ Cancer ___ Endocrine Disorders
___ Arthritis ___ Hypertension ___ Other: _____
___ Tuberculosis ___ Heart Disease _____
___ Hemophilia ___ Kidney Disease _____

Surgical History and Hospitalizations

List all surgeries and hospitalizations (Please provide the year, as well)
_____
_____
_____
_____

Primary Care Physician

Physician/Practice Name: _____
Last Visit Date: _____
Are you now, or have you been, under the care of any other doctor in the past two years? If yes, please explain: _____
_____
_____

Consent for Treatment

I certify that, to the best of my knowledge, the above information is true and correct. 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.

_____ _____
Signature of Patient or Responsible Party Date

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New Patient Information

Today's Date: _____ Date of Birth: _____
Patient Legal Name: _____
Billing Address: _____
_____
City State Zip
Mailing Address (if different from above)
_____
_____
City State Zip
Sex: Male / Female Age: _____ SSN: _____
Marital Status: Single / Married / Separated / Divorced / Widowed
Driver's License #: _____
Occupation: _____
Employer: _____
Employer Address: _____
Employer Phone: _____
Spouse's Name: _____
Spouse's DOB: _____
Referred by: Patient / Insurance Co. / Doctor / Google / Other _____, if referred by another patient, whom may we thank for referring you?
_____

Contact Information

Home Phone: _____
Cell Phone: _____
Work Phone: _____ Ext: _____
Which are you most likely to answer? When?
_____ AM / PM
Emergency Contact Information
Name: _____ Relationship: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____ Ext: _____

Medications

Include prescriptions, OTC medications, and vitamins: _____
_____
_____
Pharmacy Name(s): _____
Pharmacy Phone(s): _____
Do you take Oral Contraceptives? Yes / No

Allergies

___Adhesive Tape ___ Codeine ___ Sulfa
___Anticoagulant Therapy ___ Novocaine ___Iodine
___Aspirin ___ Penicillin ___Demerol
___ Local Anesthetics ___ Seafood
___Other: _____

Insurance Information

Policy Holder's Name: _____
Policy Holder's DOB: _____
Relationship to Patient: _____
Primary Ins Co.: _____
ID #: _____ Group #:_____
Ins Co Phone: _____
Secondary Ins Co.: _____
ID #: _____ Group #:_____
Ins Co Phone: _____
Account Responsible: _____
Relationship to Patient: _____
Preferred Method of Payment: (Please check one)
_____CASH _____CHECK _____CREDIT CARD

Assignment and Release

I, the undersigned, certify the I (or my dependent) have insurance coverage with _____
And assign all insurance benefits, if any, directly to Foot and Ankle Solutions, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. I 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.

_____
Account Responsible Signature Date

Medicare Authorization

I request the payment of authorized Medicare benefits to be made either to me or on my behalf to Foot and Ankle Solutions for any services furnished to me by physicians of Foot and Ankle Solutions. I authorize any holder of medical information about me to release to the Healthcare 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, any 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/suppliers agree to accept the charge determination of the Medicare Carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier

_____
Beneficiary Signature Date