



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

New Patient Information

Today's Date: _____ Date of Birth: _____
 Patient Legal Name: _____
 Billing Address: _____

 City _____ State _____ Zip _____
 Mailing Address (if different from above)

 Email Address: _____
 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: _____

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 _____



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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: _____ <p style="text-align: center;">Social History</p> 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. <input type="checkbox"/> Ankle Pain <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Bunions <input type="checkbox"/> Corns/Calluses <input type="checkbox"/> Cramps or Numbness in Feet/Legs <input type="checkbox"/> Flat Feet <input type="checkbox"/> Heel Pain <input type="checkbox"/> Ingrown Toenails <input type="checkbox"/> Plantar Warts <input type="checkbox"/> Swelling in Ankles/Feet <input type="checkbox"/> Tired Feet
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Medical History

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

- | | |
|---|--|
| <input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Heart, Valves, or Joints
<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Problems
<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Circulatory Problems
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear Problems
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Eye Problems
<input type="checkbox"/> Fainting
<input type="checkbox"/> Gastrointestinal Disorders
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Gout
<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Nervous Problems
<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Rash
<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Varicose Veins |
|---|--|

Family History

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

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Endocrine Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> 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