

## Patient Information Sheet

Welcome to our Office...

**Attention:** Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

Social Security# _____		E-mail: _____		
Last Name: _____		First Name: _____		Middle Initial: _____
Date of Birth: (MM/DD/YYYY) ____ / ____ / ____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Address: _____		Apt.#: _____	City: _____	State: _____ Zip: _____
Home Phone: (____) _____		Work Phone: (____) _____		Cell Phone: (____) _____
Emergency Contact: _____		Emergency Telephone#: (____) _____		
Employer Name: _____		Employer's Address / City / State / Zip _____		
Referring Doctor: _____	Referring Dr.'s Address / City / State / Zip _____		Referring Dr.'s NPI # _____	
Primary Care Physician: _____	Primary Care Physician's Address / City / State / Zip _____		P.C.P.'s NPI # _____	

**Primary Insurance Company Information:****Secondary Insurance Company Information:**

Policy Holder First Name: _____		Policy First Name: _____	
Policy Holder Last Name: _____		Policy Holder Last Name: _____	
Policy Holder's SS# _____		Policy Holder's SS# _____	
Policy Holder's Date of Birth: _____ / _____ / _____		Policy Holder's Date of Birth: _____ / _____ / _____	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Policy Holder's Address: _____		Policy Holder's Address: _____	
City: _____ State: _____ Zip: _____		City: _____ State: _____ Zip: _____	
Insurance's Name: _____		Insurance's Name: _____	
Policy ID: _____ Group #: _____		Policy ID: _____ Group #: _____	
Claim Submission Address: _____		Claim Submission Address: _____	
Effective Date: _____ / _____ / _____		Effective Date: _____ / _____ / _____	
Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No		Referral Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Responsible Party Information** – Please complete if the responsible for payment is not the Patient or the Policy Holder.

Responsible Party's Name (Last / First): _____	Responsible Party's SSN: _____	Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Responsible Party's Address / City / State / Zip: _____		

**FINANCIAL POLICY**

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill that I am responsible.

Houston Foot Specialists accepts personal checks. In the event that a check 'bounces' (i.e., insufficient funds exist to cover the check), a fee of \$25 will be applied. All patients receive a reminder call for upcoming appointments. **Failure to appear** or call to cancel 24hrs prior to an appointment (no show) will result in a \$25 fee. **By signing below, I acknowledge and agree to abide by this policy. I also acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices and I agree to comply with all of its terms.**

Today's Date: \_\_\_\_\_

Patient's Signature (or parent if patient under 18 years of age): \_\_\_\_\_

**PODIATRY HISTORY**

What is your chief complaint today? (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 any foot problems you now have or have had in the past:

- Ankle Pain .....  Yes  No
- Athlete's Foot .....  Yes  No
- Corns and Calluses .....  Yes  No
- 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                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Anesthetics          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Problem           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to Medicine or Drugs    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Foot or Leg Cramps    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problem            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke/Heart Attack      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling in Ankle, Feet  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders                | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tired Feet               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicose Veins           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Diarrhea                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuropathy            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Phlebitis             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |  |
| Ear Problem                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |  |

List any surgeries you have had \_\_\_\_\_

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

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

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

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

**ALLERGIES**

- Adhesive/Tape
- Aspirin
- Iodine
- Novocain
- Sulfa
- Anticoagulant Therapy
- Demerol
- Local Anesthetics
- Sea foods
- Other: \_\_\_\_\_

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures on me as the doctor deems necessary.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_