Welcome to Caring Foot and Ankle Specialists

Name:__________________________________ Date of Birth:____________________ Date:________________

Address:____ State:_________ Zip code:___________

Home #: ______________________ Work #: _______________________Cell Phone:____________________

Email: ____ Sex: F M Marital Status: S M D W

Social Security #: _____________________________ Employer: _____________________________________

Primary Care Physician:_________________________________ Phone#:______________________________

Insurance Subscriber Information:

Name:____ Date of Birth:__________________________________

Relationship to Patient:_________________________ Social Security #:______________________________

Emergency Contact: (someone who is not living with you)

Name:_______________________________________ Phone #:_______________________________________

State Required Ethnicity and Race Questionnaire

Texas law requires the Texas Department of State Health Services to collect information of the race/ethnic background of patients. Medical facilities are required to ask patients to identify their own race and ethnic backgrounds. The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving access to adequate health care. You are NOT REQUIRED to answer the following questions. You may mark the choice that you are declining to answer.

Question #1: Nationality or Ethnic Background

(Circle box that most accurately identifies the patient's ethnic background)

(1) Hispanic/Latino
(2) Not Hispanic/Latino
(3) I (patient or patients legal guardian) decline to answer the question

Question#2: Race

(Circle box that most accurately identifies the patient's race)

(1) American Indian/Alaskan
(2) Asian
(3) Native Hawaiian or Other Pacific Islander
(4) Black/ African American
(5) White
(6) Hispanic
(7) Other
(8) I (patient or patients legal guardian) decline to answer the question

Question #3: Preferred Language

(Circle the box that best describes the patients preferred language. This disclosure does not obligate Caring Foot and Ankle Specialists to communicate with the patient in his or her preferred language.)

(1) English (2) Spanish (3)Other:___________

(4) Sign Language

(5) I (patient or patient's legal guardian) decline to answer the question.

Patient name: ____________________________
Patient Date of birth: ______________________

Authorization and Consent for Health Care

I hereby authorize the physicians of Caring Foot and ankle Specialists and affiliated or other providers to release any information acquired in the course of my treatment to my insurance company, employee, or third-party payer as required for claims files, quality assurance, health plan administration or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and acquired immune deficiency syndrome (AIDS). I authorize direct payment to be made to the physicians of Caring Foot and Ankle Specialists or other providers for any and all medical or surgical services rendered. I understand that if any services not covered, or if Caring Foot and Ankle Specialists is unable to verify eligibility, that I am responsible for all charges incurred for services rendered. I understand that my Doctor may be an Attending Physician at hospitals that may be out of network with my insurance plan. I understand that I have the option to get my care at either an in network or an out of network facility and that if I have any questions regarding this, I can ask my Doctor or the business office for further information. I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physicians, and my physician's associates, assistants, and other healthcare providers, as may be necessary to my physician's judgement. I have relied on my physicians for information in this regard and acknowledge that no warranty or guarantee has been made to me as a result to cure. This form has been fully explained to me, and I certify that I understand its contents.

X ____ ____________

Signature of Patient, Parent, Guardian, or Responsible Party Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

X ________________________ ________________________ ____________

Signature of Patient or Guardian Description of Guardian's Authority Date

Consent for Communication of Protected Health Information

I give my consent to Caring Foot and Ankle Specialists to release Protected Health Information to the people or facilities listed below. This is to include any results of lab, diagnostic and/or therapeutic testing, including HIV testing, or my medical condition.

Name Relationship or initial here for NO other person ______

____

____

X ________________________ ________________________ ____________

Signature of Patient or Guardian Description of Guardian's Authority Date

Consent for Communication of Protected Health Information

I grant permission to Caring Foot and Ankle Specialists to view my prescription history form external sources.

X ________________________ ________________________ ____________

Signature of Patient or Guardian Description of Guardian's Authority Date

*This authorization will remain in effect until such time the patient or personal representative notifies Caring Foot and Ankle Specialists in writing of a change in release of information.

Acknowledgement and Agreement of Financial Policy

I have reviewed this office's financial policy and I agree to the terms. I understand I am responsible for deductibles, coinsurance, copays, non-covered services and no-show fees. I also understand that if I fail to pay charges, I imply discontinuation of podiatry services.

X ________________________ ________________________ ____________

Signature of Patient or Guardian Description of Guardian's Authority Date

Name:__________________________________**Date of Birth:** ___/__/__ **Appointment Date:**___/___/___

Reason for Visit: *(Please be as specific as possible)*

____

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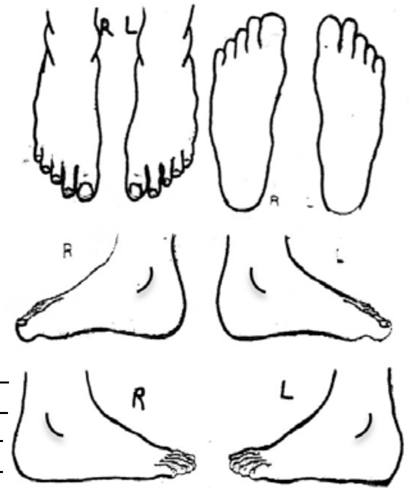

Location: *please mark areas of specific area of concern on the diagrams* à

Amount of pain: on 1-10 scale; 10 being worst pain:_____/10

(Please be specific by circling all that apply)

Nature of pain: Dull, Sharp, Shooting, electric, Tingling, Itching, Burning
Duration: Constant, Intermittent, Flare-ups *(how often?____________)*
Onset of Symptoms:______days,_____weeks,_____years ago
Date of initial injury: _/ _/____
Location of injury: home, work, automobile, other:______________________
What makes the pain worse?: walking, weight-bearing, after rest, __________

____

Treatments already tried:____
Shoe Size:_____, *Men's/Women's/Wide/Narrow*

Primary Medical Doctor: _______________________________ **Date of Last Visit:**_____/_____/______

Doctor Treating for Diabetes: ___________________________ **Date of Last Visit:**_____/_____/______

Former Podiatrist:______________________________________**Date of Last Visit:**_____/_____/______

MEDICAL HISTORY *(Please Circle only those items that apply)*:

Alzheimer's / Dementia
Anemia
Anxiety / Depression
Arthritis: Rheumatoid / Osteoarthritis / Lupus / Gouty
Artificial Heart Valves or Joints
Asthma / Emphysema / Lung Problem
Autoimmune Disease / HIV / AIDS
Back Problems / Herniated Discs
Blood Disease / Bleeding Disorders
Blood Clots / DVT
Broken Bones in Feet / Legs
Cancer – Type__________________
Charcot Joint
Chemical Dependency – Type_____

Chronic Diarrhea
Circulatory Problems
Cramps in feet or legs
CVA (Stroke) / TIAs
Diabetes: Diet / Oral / Insulin # Yrs
Epilepsy / Fainting / Seizures
Fibromyalgia – Chronic pain disorder
Gastric Reflux / Hiatal Hernia
GI Ulcers / Stomach Problems
Gout
Heart Attack / MI
Heart Disease / Angina / Chest Pain
High Blood Pressure
High Cholesterol

Joint Replacements: Knee / Hip
Kidney Disease / Dialysis
Liver Disease / Hepatitis / Jaundice
Lyme's Disease
Neuropathy / MS
Osteoporosis
Peripheral Vascular Disease
Rheumatic Fever
Skin Problems / Psoriasis
Thyroid Problems / Hypothyroidism
Varicose Veins
Weight Loss / Gain (Unexplained)
If over 65 – History of Falls

Other Medical Problems *(Please List)*: ____

PAST SURGICAL HISTORY (*Please Circle only those items that apply*): NONE ❑

Foot surgery: Type______________________________**Date:**____/___/_____**Right or Left (Please Circle)**
Surgeon name: ____________________________
Other Surgeries:

Amputation
Angioplasty or Stenting
Appendectomy
Arterial Bypass
Back Surgery
Breast Biopsy / Lumpectomy
C-Section
Cataract Surgery
Carotid Artery Surgery

D & C
Gall Bladder Removal
Heart Bypass Surgery
Hernia Repair
Hip Joint Replacement
Hysterectomy
Kidney Stones
Kidney Removal
Knee Replacement

Mastectomy
Other Joint Replacement
Pacemaker
Plastic Surgery
Prostate Surgery
Tonsillectomy
Venous Ligation
Wound Care

Other unlisted surgery: ____

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Name:_________________________________**Date of Birth:** ___/___/___ **Appointment Date:**___/___/___

<u>Medications</u> (Please List — Include Non-Prescription Medications): **NONE** ❑

Drug Name *Dose* *Times taken per day,* *Prescriber*

____

____

____

Pharmacy: ___________________ Address: ______________________ Phone: ______________ Fax: _____________

FAMILY HISTORY (Please circle if positive)

	Arthritis	**Diabetes**	**Heart Disease**	**Cancer**	**High Blood Pressure**
Mother	yes	yes	yes	yes	yes
Father	yes	yes	yes	yes	yes
Siblings	yes	yes	yes	yes	yes

Personal or Family History of Blood Clots? Yes / No **Details:** ______________________________

SOCIAL HISTORY *(Please Circle those items that apply):* **NONE**

Alcohol use: Yes or No, _________# of drinks per Week. Past History of Alcohol Abuse: Yes or No
Tobacco use: Yes or No, _________# of packs per Day _____# of years smoking
Recreational Drug use: Yes or No, Past IV drug use: Yes or No
Sport or Exercise Activities: ____

ALLERGIES (Circle only those items that apply): ***No Known Drug Allergies*** ❑

Novocain	**Adhesive Tape**	**Motrin / Advil**
Aspirin	**Latex**	**Cortisone**
Codeine	**Iodine**	**Sulfa**
Penicillin	**Neosporin**	**Other:** ____________________________

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REVIEW OF SYSTEMS - Have you <u>currently</u> have any of the following Symptoms or Problems?

Head & Eyes: Dizziness / Fainting / Headaches / Double Vision / Infection
Ear Nose or Throat: Difficulty Swallowing / Hearing Loss / Infection / Earaches / Sores / Nosebleed
Respiratory: Asthma / Bronchitis / Difficulty Breathing / Shortness of Breath / Vomiting Blood
Cardiovascular: Hypertension / Murmurs / Chest Pain / Edema / Claudication / Ulceration /Phlebitis
Gastrointestinal: Jaundice / Cirrhosis / Hepatitis / Abnormal Stool
Musculoskeletal: Joint Pain or Swelling / Back Pain / Pain with Activity After Resting / Weakness /
Neurologic Paralysis / Stroke / Tics / Tremors / Seizures / Numbness
Dermatology Rash / Thickened Discolored Nails
Mental Status: Alert and Oriented / Alert, Not Oriented / Confused / Lethargic

- -

FOR OFFICE USE

Temp:____°, **Pulse** _____, **Respirations**____, **BP**___/___, **Height:**___'__", **Weight:**____**lbs, Shoe Size:**______,