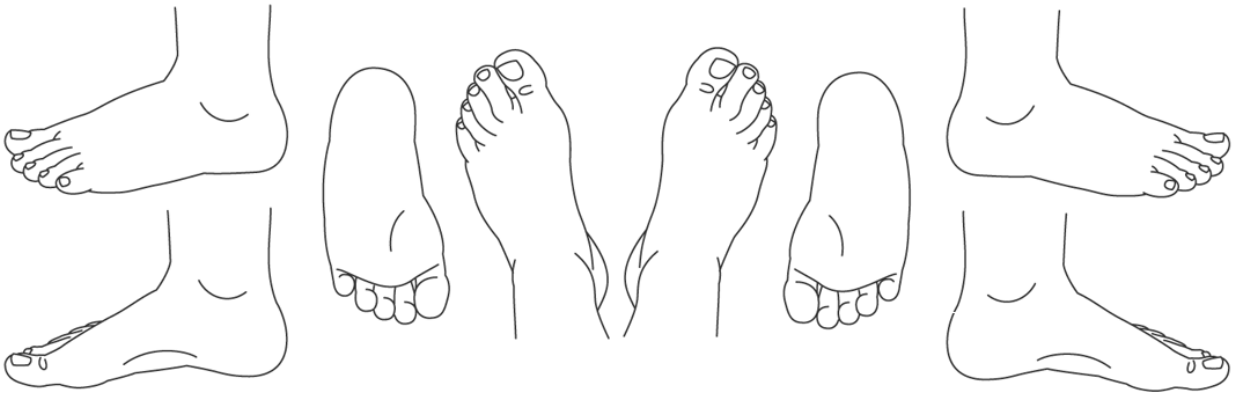
Name: _____ Date: _____ ☐ The Woodlands Office

DOB: _____ ☐ Woodville Office

What foot problems are you having looked at today? Please mark the location of your problem.

1. _____ 3. _____

2. _____ 4. _____



LEFT **RIGHT**

Please describe how this happened (injury, trauma, don't know)

How long have you had this problem, and has it improved, stayed the same, or worsened?

What improves your symptoms?

What worsens your symptoms?

What treatments have you attempted for your symptoms?

Medical History

☐ AIDS/HIV	☐ Foot/Leg cramps	☐ Radiation treatment
☐ Anemia	☐ Gout	☐ Rash
☐ Arthritis	☐ Heart disease	☐ Respiratory disease
☐ Artificial valves/joints	☐ Hemophilia	☐ Rheumatic fever
☐ Asthma	☐ Hepatitis/Jaundice	☐ Sinus problem
☐ Back problems	☐ High blood pressure	☐ Stroke
☐ Bleeding disorders	☐ Kidney disease	☐ Swelling in ankles/feet
☐ Cancer	☐ Liver disease	☐ Tuberculosis
☐ Chemical dependency	☐ Low blood pressure	☐ Ulcers
☐ Chemotherapy	☐ Neuropathy	☐ Varicose veins
☐ Diabetes	☐ Peripheral arterial dise.	☐ Venous disease
☐ Epilepsy	☐ Phlebitis	☐ Other: _____

Surgical History (Procedure **-** Date)

• -	• -
• -	• -
• -	• -
• -	• -

Family History

please check any of the following illnesses if they run in your family, and circle the family member involved (**M**=mother, **F**=father, **S**=sibling, **GP**=grandparent).

☐ Arthritis	**M F S GP**	☐ High Cholesterol	**M F S GP**
☐ Cancer	**M F S GP**	☐ Hypertension	**M F S GP**
☐ Diabetes	**M F S GP**	☐ Kidney Disease	**M F S GP**
☐ Heart Disease	**M F S GP**	☐ Other: _____	**M F S GP**

Preferred Pharmacy: **Preferred Pharmacy Phone #: ( )**

Medication List

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Allergies and Reactions

- _____
- _____
- _____
- _____

Smoking

☐ Every day
☐ Some day
☐ Former
☐ Never

Drinking

☐ Frequent
☐ Occasional
☐ Seldom
☐ Never

Drug use

☐ Yes: _____
☐ No

Review of Systems (check the following if they apply to you right now)

Constitutional

☐ Fever
☐ Chills
☐ Night sweats

HEENT

☐ Headache
☐ Blurred Vision
☐ Nose bleed
☐ Hearing problems
☐ Difficulty swallowing

Cardiovascular/Resp.

☐ Chest pain
☐ Shortness of breath
☐ Wheezing
☐ Coughing

Gastrointestinal/Genitourinary

☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea

Musculoskeletal

☐ Joint pain
☐ Muscle soreness
☐ Muscle weakness
☐ Back pain
☐ Numbness

Patient Information Sheet

Social Security #:

First Name: Last Name: Middle Initial:

DOB: (MM/DD/YYYY) Age: Gender: Marital Status:

/ / ☐Male ☐Female ☐Single ☐Married ☐Other

Email Address:

Address: Apt #: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

( ) ( ) ( )

Emergency Contact: Emergency Telephone #:

( )

Employer Name: Employer's Address / City / State / ZIP:

Primary Care Physician: PCP's Address / City / State / ZIP:

Primary Insurance Company Information:

Policy Holder First & Last Name:

Policy Holder's SS #: Policy Holder's DOB:

/ /

Gender: Relationship to Policy Holder:

☐Male ☐Female ☐Self ☐Spouse ☐Child

☐Other _____

Policy Holder's Address:

City State ZIP

Policy ID Group #

Claim Submission Address

Effective Date: (MM/DD/YYYY)

/ /

Do you have a copay? ☐No ☐Yes, amt$

Referral Required? ☐No ☐Yes

Secondary Insurance Company Information

Policy Holder First & Last Name:

Policy Holder's SS #: Policy Holder's DOB:

/ /

Gender: Relationship to Policy Holder:

☐Male ☐Female ☐Self ☐Spouse ☐Child

☐Other_____

Policy Holder's Address:

City State ZIP

Policy ID Group #

Claim Submission Address

Effective Date: (MM/DD/YYYY)

/ /

Do you have a copay? ☐No ☐Yes, amt$

Referral Required? ☐No ☐Yes

Responsible Party Information (Please complete if the policy holder/payer is not the patient or the policy holder)

Responsible Party's First & Last Name: Responsible Party's Address / City / State / ZIP

Social Security #: Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physican 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.

☐ **I have received the Confidentiality Agreement (HIPAA) and agree to comply with all its terms**

Signature: **Date:**

Office and Financial Policies

Initial: _____ The patient is responsible for knowing their insurance benefits and if you have a deductible or copayement, If you have an HMO policy, you must have a referral from your PCP. If you do not have a referral for the day of your appointment, you will be asked to reschedule or will be responsible for the charges for that day. We will not become involved in disputes between your and your insurance company regarding coverage and/or benefits. You are responsible for timely payment to your account.

Initial: _____ Payments are due opon checkout as well as any past balances on your account. We accept cash, check, Visa, Masercard, Amex, and Discover.

Initial: _____ A $30.00 service free will be assessed on all dishonored checks. The full amount of the check writeetn plus $30.00 must be paid by cash or credit card. If payment is not received within 10-15 business days, your information will be filed with the Montgomery County Hot Check Division. We will be unable to see you until your payment is made in full. If you have 2 occurances of this, we will no longer accept checks from you.

Initial: _____ We do our best to stay on schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more thant 15 minutes late, you may be asked to reschedule your appointment. Cancellations are required 24 hours prior to your appointment. There could be a $25.00 charge for a no-show.

Initial: _____ It is the patient's responsibility to call the pharmacy 5 days prior to running out of medication. Refills may take between 3-4 days to be refilled. Please do not call/leave messages multiple times, as this will slow down the process.

Initial: _____ There will be a $25.00 fee for the review and completion of leave of absence forms that must be signed by the doctor.

Printed Name: Date: (MM/DD/YYYY)

/ /

Please list the names of the persons with whom we can discuss your medical information with.

- _____
- _____
- _____
- _____

Do you consent to a medical exam and any procedures or tests deemed necessary by our doctor while you are in the office?

☐Yes ☐No

Do you wish for our office to release your medical information to any specialists that we refer you to?

☐Yes ☐No

Do you consent to the staff releasing information about appointments and/or text results to someone on your list?

☐Yes ☐No

I have read, understood, and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information, and authorize the release of information for insurance filing and pre-certification by signing this statement.

Printed Name:

_____

Signature: Date: (MM/DD/YYYY)

_____ / /