

FOOT SPECIALIST OF TEXAS CITY
PATIENT REGISTRATION FORM

This information is confidential

Office Use Only EHS Pt.# _____

PATIENT INFORMATION

Name _____

Address _____

City _____

State _____ Zip _____

Telephone (____) _____

E-mail: _____

Social Security # _____

Male Female

Single Married Widowed Divorced

American Indian or Alaska Native Asian White

Black or African American Native Hawaiian

Hispanic Latino Other

Date of Birth _____

Occupation _____

Employer _____

Address _____

Work Phone (____) _____ Ext _____

Cell Phone (____) _____

Spouse Information (If Applicable)

Name _____

Home Phone _____

Work Phone _____ Ext _____

Primary Physician _____

Referring Physician _____

INSURANCE INFORMATION

Primary- Ins. Co. Name _____

Policyholder Name _____

Self Spouse

Policyholders Date of Birth ____/____/____

Employer _____

Secondary- Ins. Co. Name _____

Policyholder Name _____

Policyholders Date of Birth ____/____/____

Self Spouse

PHARMACY INFORMATION

Pharmacy Name _____

Address _____

City _____ State _____

EMERGENCY CONTACT (If other than Spouse)

Name _____

Relationship: _____

Telephone(____) _____

Complete only if patient is under age 18

Name _____

Address _____

City _____

State _____ Zip _____

Telephone(____) _____

SS# _____ DOB _____

Occupation _____

Employer _____

Address _____

Work Phone(____) _____ Ext _____

Is your treatment today due to:

.....a work related injury Yes No

Injury Date _____

Do you have written authorization from your employer and comp carrier to be treated Yes No

.....a motor vehicle accident Yes No

Accident Date _____

.....a an accident/ liability case Yes No

Accident Date _____

Whom may we thank for sending you to our office?

Doctor _____

Patient _____

Newspaper _____

Other _____

Verizon Yellow Pages

The Yellow Book

Insurance Provider List

Passed by Location Health Fair

I hereby authorize the release of any medical information pertaining to my treatment or information necessary for processing insurance claims and payment of medical benefits to myself or the party who accepts assignments. This authorization will remain valid until revoked by me in writing. I understand that I am legally responsible for all charges whether or not reimbursed by my insurance company.

Signature X _____

Date _____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf of **FOOT SPECIALIST OF TEXAS CITY** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to 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, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S NAME (Please Print)		PROVIDER: Name, Address, and Zip	
		FOOT SPECIALIST OF TEXAS CITY 3200 PALMER WAY TEXAS CITY, TX 77590	
PATIENT'S SIGNATURE			
PATIENT'S MEDICARE NO.	DATE		

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY POLICY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the notice.

Patient Name (Please Print)

Date

Parent or Authorized Representative (If Applicable)

Signature

History & Medical Information

1. **Explain your foot/ankle problem** Right Left _____
2. **Describe the pain/discomfort:** Burning Numbness Sharp Other _____
3. **When did the pain/discomfort begin?** _____
4. **What makes the pain/discomfort better:** _____
5. **What makes the pain/discomfort worst:** _____
6. **List all medications/herbs/vitamins:** NONE _____
7. **List all drug, food and environmental allergies and describe reaction:** NONE
 Penicillin _____ Aspirin _____ Narcotic Agent / Codeine _____
 Anesthesia _____ Shellfish _____ Sulfa Drugs _____
 Nickel / Metal _____ Radiographic Contrast Dye _____
 Other _____

8. Past Medical and Family History

Condition	Self	Family	Condition	Self	Family
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nails Disorders	<input type="checkbox"/>	<input type="checkbox"/>
How long have you been diabetic?			Nerve Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Avg Glucose _____	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Foot Problem(s)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intest Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Injury Trauma - Major	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

9. **Surgical History:** Have you had surgery? Yes—if yes, describe below No
Surgery / Date: _____
10. **Social History:** (Only check what is pertinent to you)

Do you have a history of:	Yes	No		Yes	No
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine Use	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	Drug Use	<input type="checkbox"/>	<input type="checkbox"/>
11. **Do you exercise?** Yes No _____
12. **Occupation:** _____ **Is your problem work related?** Yes No
13. **Are you currently pregnant?** Yes No _____
14. **Height:** _____ **Weight:** _____ **Shoe Size:** _____

ALL OF THE INFORMATION PROVIDED TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE:

Signature: _____ Print Name: _____ Date: _____

Review of Systems

Please check any of the following that you are **currently experiencing** or have **recently experienced**.

Constitutional:	Y N	Have you felt rigidity in your legs?	<input type="checkbox"/> <input type="checkbox"/>
Generally do you feel well?	<input type="checkbox"/> <input type="checkbox"/>	Do you limp when you walk?	<input type="checkbox"/> <input type="checkbox"/>
Do you feel fatigued during the day?	<input type="checkbox"/> <input type="checkbox"/>	Do your shoes wear out quickly or unevenly?	<input type="checkbox"/> <input type="checkbox"/>
Does your problem limit your normal daily activities?	<input type="checkbox"/> <input type="checkbox"/>	Integumentary (Skin):	Y N
Do you have a fever?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any skin problems?	<input type="checkbox"/> <input type="checkbox"/>
Eyes:	Y N	Is your skin strongly sensitive when exposed to the sun?	<input type="checkbox"/> <input type="checkbox"/>
Do you wear glasses or contacts?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any skin rashes?	<input type="checkbox"/> <input type="checkbox"/>
Do you have burning or itchy eyes?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any warts on your feet?	<input type="checkbox"/> <input type="checkbox"/>
Do you have sensitivity to light?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any moles, lumps, bumps on your skin?	<input type="checkbox"/> <input type="checkbox"/>
Do you have watering of your eyes?	<input type="checkbox"/> <input type="checkbox"/>	Do you have extremely dry skin or cracking?	<input type="checkbox"/> <input type="checkbox"/>
Are your eyes frequently red?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any open skin sores?	<input type="checkbox"/> <input type="checkbox"/>
Do you have eye pain?	<input type="checkbox"/> <input type="checkbox"/>	Are there unusual areas of discoloration on your skin?	<input type="checkbox"/> <input type="checkbox"/>
Ears, nose, mouth & throat:	Y N	Do you have any corns or calluses on your feet?	<input type="checkbox"/> <input type="checkbox"/>
Do you have ringing in your ears?	<input type="checkbox"/> <input type="checkbox"/>	Are your nails unusually thick?	<input type="checkbox"/> <input type="checkbox"/>
Do you get nosebleeds?	<input type="checkbox"/> <input type="checkbox"/>	Are your nails deformed?	<input type="checkbox"/> <input type="checkbox"/>
Do you have difficulty swallowing?	<input type="checkbox"/> <input type="checkbox"/>	Are your nails ingrown and tender?	<input type="checkbox"/> <input type="checkbox"/>
Cardiovascular:	Y N	Do your nails cause you pain?	<input type="checkbox"/> <input type="checkbox"/>
Have you noticed your legs or ankles swelling?	<input type="checkbox"/> <input type="checkbox"/>	Do you have problems with your fingernails?	<input type="checkbox"/> <input type="checkbox"/>
Do you have varicose veins?	<input type="checkbox"/> <input type="checkbox"/>	Do you have noticeable hair loss on your legs or feet?	<input type="checkbox"/> <input type="checkbox"/>
Do you have cramps in your legs at night or at rest?	<input type="checkbox"/> <input type="checkbox"/>	Neurological	Y N
Do you have cramps in your legs when walking?	<input type="checkbox"/> <input type="checkbox"/>	Do you ever feel dizzy?	<input type="checkbox"/> <input type="checkbox"/>
Do your feet feel especially cold?	<input type="checkbox"/> <input type="checkbox"/>	Do you often feel confused?	<input type="checkbox"/> <input type="checkbox"/>
Respiratory:	Y N	Do you often feel disoriented?	<input type="checkbox"/> <input type="checkbox"/>
Do you have chest pain?	<input type="checkbox"/> <input type="checkbox"/>	Do you have problems with your balance?	<input type="checkbox"/> <input type="checkbox"/>
Do you have difficulty breathing?	<input type="checkbox"/> <input type="checkbox"/>	Do you have frequent or reoccurring headaches?	<input type="checkbox"/> <input type="checkbox"/>
Do you have shortness of breath?	<input type="checkbox"/> <input type="checkbox"/>	Do you have seizures?	<input type="checkbox"/> <input type="checkbox"/>
Have you had a cough lasting longer than 3 weeks?	<input type="checkbox"/> <input type="checkbox"/>	Do you have tremors of your extremities?	<input type="checkbox"/> <input type="checkbox"/>
Gastrointestinal:	Y N	Do your legs often feel like they "are going to sleep"?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a loss or increase in appetite?	<input type="checkbox"/> <input type="checkbox"/>	Do you have numbness in your legs?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a history of stomach ulcers?	<input type="checkbox"/> <input type="checkbox"/>	-a feeling of burning in your legs?	<input type="checkbox"/> <input type="checkbox"/>
Do you have heartburn?	<input type="checkbox"/> <input type="checkbox"/>	-cramps or pain in the legs with walking or exercise?	<input type="checkbox"/> <input type="checkbox"/>
Does Aspirin cause stomach pain?	<input type="checkbox"/> <input type="checkbox"/>	-leg pain that is worse at night or at rest?	<input type="checkbox"/> <input type="checkbox"/>
Do you have bloody or dark stools?	<input type="checkbox"/> <input type="checkbox"/>	-leg pain all the time?	<input type="checkbox"/> <input type="checkbox"/>
Genitourinary:	Y N	-experience shooting pain down your legs?	<input type="checkbox"/> <input type="checkbox"/>
Do you urinate more frequently than before?	<input type="checkbox"/> <input type="checkbox"/>	-paralysis (complete loss of muscle strength) in legs?	<input type="checkbox"/> <input type="checkbox"/>
Do you have pain with urination?	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric:	Y N
Do you have burning with urination?	<input type="checkbox"/> <input type="checkbox"/>	Do you have a history of psychiatric problems?	<input type="checkbox"/> <input type="checkbox"/>
Have you noticed blood in your urine?	<input type="checkbox"/> <input type="checkbox"/>	Are you subject to mood swings?	<input type="checkbox"/> <input type="checkbox"/>
Musculoskeletal:	Y N	Are you under a lot of stress?	<input type="checkbox"/> <input type="checkbox"/>
Do you have low back pain?	<input type="checkbox"/> <input type="checkbox"/>	Endocrine:	Y N
Do you have pain in your legs?	<input type="checkbox"/> <input type="checkbox"/>	Do you urinate more frequently than before?	<input type="checkbox"/> <input type="checkbox"/>
Do you have foot pain?	<input type="checkbox"/> <input type="checkbox"/>	Are you excessively thirsty?	<input type="checkbox"/> <input type="checkbox"/>
Do you have joint pain?	<input type="checkbox"/> <input type="checkbox"/>	Do you have a history of bad breath?	<input type="checkbox"/> <input type="checkbox"/>
Do you have bone pain?	<input type="checkbox"/> <input type="checkbox"/>	Are you experiencing night sweats?	<input type="checkbox"/> <input type="checkbox"/>
Do you have general muscle aches or pains?	<input type="checkbox"/> <input type="checkbox"/>	Do you have swollen glands?	<input type="checkbox"/> <input type="checkbox"/>
Have you had swelling in your legs?	<input type="checkbox"/> <input type="checkbox"/>	Have you had a significant weight change recently?	<input type="checkbox"/> <input type="checkbox"/>
Have you had joint swelling?	<input type="checkbox"/> <input type="checkbox"/>	Hematologic / Lymphatic	Y N
Have you had joint stiffness?	<input type="checkbox"/> <input type="checkbox"/>	Do you bruise easily?	<input type="checkbox"/> <input type="checkbox"/>
Have you noticed a change in the way you walk?	<input type="checkbox"/> <input type="checkbox"/>	Allergic / Immunologic:	Y N
Is it difficult to climb stairs?	<input type="checkbox"/> <input type="checkbox"/>	If you get cut, does it take a long time to heal?	<input type="checkbox"/> <input type="checkbox"/>
Are you experiencing a loss of strength in your legs?	<input type="checkbox"/> <input type="checkbox"/>	Do you have allergic reactions to medication, foods dye?	<input type="checkbox"/> <input type="checkbox"/>

PAYMENT POLICY

INSURANCE COVERED ACCOUNT:

Charges for services that are covered by your insurance carrier contracted with us will be filed and due in full within 45 days from the date the claim was filed per the Texas Clean Claim Law. If this fails to occur, you will be notified to assist in recovering payment from your insurance carrier.

INSURANCE FAILURE TO PAY:

Failure of the insurance carrier to pay us for charges on behalf of the insured within 90 days of billing a clean claim will result in the insured assuming responsibility for the entire bill as a non-insured account. Billed charges discounted by contracted insurances are written off by us. Any billed charges deemed non-covered are the responsibility of the insured.

PAYMENTS ARE DUE AT THE TIME OF SERVICE:

All non-insured patients are expected to pay for services at the time of the visit unless prior arrangements have been made.

All insured patients are asked to pay any co-payment, deductible, or percentage not covered at the time of service. Most insurances require patients to pay a deductible and or portions of the covered charges. Payment at the time of service allows us to concentrate on patient care instead of sending bills and calling patients on their accounts. Not all patients are responsible as you and force us to send repeated bills and phone calls to try and collect monies due to this office. Therefore, this standard policy is necessary to keep cost down. Any remaining balance after your insurance has paid, due to underpayment at the time of visit, will become a patient bill as allowed by your insurance. Any refunds due to insurance overpayment, will likewise be refunded promptly as required by your insurance company.

PAYMENTS DIRECT RESPONSIBILITY:

You are responsible to us for payment of your account regardless of the status of your insurance claim. In the rare instance that an account is left unpaid according to the above policy and after proper notification, will be turned over to our collection agency.

AGREEMENT:

I have reviewed this document entirely, and agree to its terms and conditions of treatment.

Signature _____ Date _____