Jack Sasiene DPM

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____ _____

Address_____ _____

City, State _____ Zip_____

Telephone (_____)_____

E-mail _____

SS# _____

□ Male □ Female

□ Single □ Married □ Widow □ Divorced

□ American Indian or Alaska Native □ Asian

□ Black or African American □ White

□ Native Hawaiian □ Hispanic Latino □ Other

Date of Birth _____

Occupation _____

Employer _____

Employer Address_____

City, State_____ Zip_____

Work Phone (___)_____

Cell Phone (___)_____

SPOUSE INFORMATION (if applicable)

Name_____

Home Phone (___)_____

Work Phone (___)_____

PHARMACY INFORMATION

Pharmacy Name _____

Address_____

City, State _____ Zip_____

EMERGENCY CONTACT (if other than spouse)

Name_____

Relationship_____

Telephone (____)_____

PARENT INFORMATION

COMPLETE IF PATIENT IS UNDER AGE 18

Name_____

Address_____

City, State_____ Zip _____

Telephone (___)_____

SS# _____

Occupation_____

Employer_____

Employer Address_____

City, State_____ Zip_____

Work Phone (___)_____

PHYSICIANS INFORMATION

Primary Physician_____

Office Number (___)_____

Referring Physician_____

Patient Name: _____ **Date:** _____

MEDICAL HISTORY INFORMATION

Explain your foot/ankle problem ☐ **Right** ☐ **Left** _____
Describe the pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other_____
When did the pain/discomfort begin? _____
What makes the pain/discomfort better? _____
What makes the pain/discomfort worse? _____

Do you Exercise? ☐ No ☐ Yes **If Yes, Explain:**_____
Occupation: _____ **Is your problem work related?** _____
Are you currently pregnant? ☐ No ☐ Yes **If Yes, When are you due?** _____

MEDICATIONS: ☐ **None**

_____

_____

ALLERGIES: ☐ **None** ☐ Penicillin ☐ Aspirin ☐ Shellfish ☐ Narcotic Agent/Codeine ☐ Anesthesia ☐ Sulfa Drugs ☐ Nickel/Metal ☐ IVP Contrast Dye ☐ Other_____

SOCIAL HISTORY:
Tobacco Use ____ Yes/No How long ? _____ **Alcohol Use** Yes/ No Frequency ? _____ **Drug Use** Yes/No

MEDICAL HISTORY

___Anemia
___Arthritis
___Asthma
___Bleeding Disorders
___Cancer
___Circulation Problems
___Diabetes:
Glucose _____How long? _____
___Gout
___Heart Disease
___Hepatitis Type ____
___High Blood Pressure
___High Cholesterol
___HIV/AIDS
___Major Injury/Trauma
___Kidney Disease
___Liver Disease
___Mental Retardation
___Mitral Valve Prolapse
___Multiple Sclerosis
___Nail Disorders
___Nerve Disorders
___Obesity
___Phlebitis
___Skin Problems
___Thyroid Disorders
___Stroke
___Stomach/Intest Problem
___Varicose Veins

SURGICAL HISTORY: **Have you had surgery?** ☐ **Yes** If Yes, List them Below ☐ **No**

_____

_____

FAMILY HISTORY:

	List who		List who		List who
___ Anemia	_____	___ Hypertension	_____	___ Nail Disorders	_____
___ Arthritis	_____	___ HIV/AIDS	_____	___ Nerve Disorders	_____
___ Asthma	_____	___ Major Injury	_____	___ Obesity	_____
___ Cancer	_____	___ Kidney Disease	_____	___ Phlebitis	_____
___ Diabetes	_____	___ Liver Disease	_____	___ Skin issues	_____
___ Gout	_____	___ Mental Retardation	_____	___ Thyroid	_____
___ Heart Disease	_____	___ Mitral Valve Prolaspe	_____	___ Stroke	_____
___ Hepatitis	_____	___ Multiple Sclerosis	_____	___ GERD	_____
				___Varicose Veins	_____

PATIENT/LEGAL GUARDIAN NAME SIGNATURE_____

REVIEW OF SYSTEMS:

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

Constitutional

____ Chills ____ Fatigue ___Fever ____Weakness ____Weight loss

Head

___Dizziness ___Fainting ____Headaches

Respiratory

___Asthma ___Short of breath ___Wheezing ___COPD ___Bronchitis ___TB

Cardiovascular

___Hair loss on Legs ___Leg or Foot Ulcers ___Vascular Graft/Stents ___Heart Murmur

___Cramps in legs or feet ___Replacement heart valve___Cold Feet ___History of heart attack

Gastrointestinal

___Liver disease ___Hepatitis ___Antacid Use ___Nausea ___Excessive thirst ___Gall Bladder Disease

Musculoskeletal

___Joint Stiffness ___Lower Back Pain ___Joint Implants ___Restricted Motion

Psychiatric

___Depression ___Anxiety ___Memory Loss

Skin

___Eczema ___Dryness ___Athletes Foot ___Keloid Scars ___Itching ___Ugly Toe Nails

Neurological

___Burning ___Fainting ___Strokes ___Unsteady Balance ___Numbness ___Tingling

Endocrine

___Sweats___Thyroid

Hematologic/Lymph

___Bruises Easily ___Slow Healing Cuts ___Bleeds Easily

___Recent Chemo/Radiation ___Blood Clots

Height: _____ Weight: _____ Shoe Size: _____

BY SIGNING I CONSENT THAT ALL THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT/LEGAL GUARDIAN NAME SIGNATURE _____

PATIENT ACKOWLEDGEMENTS & AGREEMENTS

Acknowledgements & Agreements

By signing, I acknowledge and agree to the following:

• I, as the responsible party, have entered the information in the patient registration form accurately and truthfully to the best of my knowledge.

• I have received or had the opportunity to read the CLS Health Patient Care Guide explaining my rights, responsibilities, and CLS Health's policies.

• I will seek clarification on any unclear details and can request the CLS Health Patient Care Guide at any time.

• I agree to the terms outlined in the CLS Health Patient Care Guide and acknowledge CLS Health will retain this form in my records.

Patient/Guardian Name: _____ **Signature:** _____ **Date:**_____

IMAGING DISCLOSURE STATEMENT

Your physician has referred you to an imaging center owned by CLS Health for MRI, CT, Ultra-Sound and/or X-ray services. By signing this notice, you acknowledge that you may choose any imaging service supplier other than the one your physician has referred you to.

For your convenience, we have listed imaging services suppliers within a 25-mile radius of our office that provide.

MRI, CT, Ultra-Sound and X-ray services as of September 2023:

HCA Houston Healthcare Mainland
6801 Emmett F Lowry Expy, Texas City, TX 77591
409.938.5000

Pulse Imaging
202 N Texas Ave Suite 500, Webster, TX 77598
281.238.2555

Gulf Coast MRI and Diagnostic
830 Gemini St, Houston, TX 77058
281.488.7226

KingsPoint Medical Imaging Inc
14200 Gulf Freeway, Houston, TX 77034
713.943.9933

Lakeside Open MRI and Diagnostic Center
17360 TX-3, Webster, TX 77598
281.338.5575

CHI St Luke's Health Brazosport
100 Medical Drive, Lake Jackson, TX 77566
979.297.4411

Alliance MRI of Clear Lake
17490 TX-3 Suite B400, Webster, TX 77598
713.351.4976

Alliance MRI of Angleton
2760 Brazos Pkwy Ste B, Angleton, TX 77515
979.849.5700

Patient/Guardian Name: _____ **Signature:** _____ **Date:** _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

PHONE (_____)_____ ALT. PHONE (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____ Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Dr. Jack A. Sasiene DPM, PA

Address 3200 Palmer Hwy Texas City / 201 Oak Drive South Ste 108

City Texas City / Lake Jackson State Texas Zip Code 77590 / 77566

Phone (409) 948-4848 / (979) 297-7798 Fax (409) 948-6042 / (979) 297-7522

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Radiology Reports & Images
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

SIGNATURE X_____ _____

Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____

Signature of Minor Individual **DATE**