FAMILY FOOT & ANKLE CENTERS

ORTHOPEDIC INTAKE FORM

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____ Sex ❒ M ❒ F

Date of Birth _____ Age _____ Social Security # _____

Address _____ City _____ Zip _____

Who can we thank for referring you/ how did you find us? _____

Family Physician _____ City _____ Date of Last Visit _____

Pharmacy _____ City _____

Height _____ Weight _____ Shoe Size _____

PHONE NUMBERS

Home Phone _____ Cell Phone _____

Email _____

In case of emergency, please contact:

Name _____ Phone _____

EMPLOYMENT

Name of Employer _____ City _____

At your job do you: ❒ sit mostly ❒ stand mostly ❒ sit and stand

Are you required to wear a specific type of shoe/ boot? _____

REVIEW OF SYSTEMS Please check all that apply

Nerve:	❒ Foot Burning ❒ Foot Numbness ❒ Seizure ❒ Loss of Balance
Skin:	❒ Rash ❒ Skin Sores ❒ Itching ❒ Dry Skin ❒ Toenail Changes
Orthopedic:	❒ Joint Pain ❒ Muscle Pain ❒ Leg Cramps ❒ Weakness ❒ Knee Pain ❒ Back Pain

REASON FOR VISIT

Reason for today's visit _____ How Long? _____

Severity of Pain or condition ❒ Mild ❒ Moderate ❒ Severe ❒ Severe at times

Type of pain (if painful) ❒ Sharp ❒ Dull ❒ Stabbing ❒ Aching ❒ Burning ❒ Other _____

This problem is ❒ Improving ❒ Worsening ❒ Unchanged

What makes it worse ❒ Activity ❒ Exercise ❒ Work ❒ Laying in Bed ❒ Other _____

What makes it better ❒ Rest ❒ Ice ❒ Heat ❒ Elevation ❒ Other _____

What treatments have you tried, if any? _____

MEDICAL HISTORY Please check the ones that apply

❒ AIDS / HIV
❒ Diabetes (Insulin)
❒ Diabetes (No Insulin)
❒ Arthritis
❒ High Blood Pressure
❒ Stroke (CVA)
❒ Heart Trouble
❒ Kidney Disease
❒ Lung Disease (COPD)
❒ Hepatitis (A, B, C)
❒ Stomach Problems
❒ Anxiety / Depression
❒ Gout
❒ Fibromyalgia
❒ Blood Clots
❒ Artificial Joints
❒ Cancer: _____

FINANCIAL POLICY

I give permission to Podiatric Medical Partners of Texas to examine/treat me during the care of my condition. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize use of this signature for all insurance claims (including Medicare/Medicaid if applicable).

Signature _____ *Date* _____

PFSH

Past Surgeries _____

Do you smoke tobacco? ❒ Yes ❒ No If yes, how many packs per day? _____

Do you drink alcohol? ❒ No ❒ Occasional ❒ Moderate ❒ Heavy

Circle all that apply. Family History of: Diabetes, Gout, Flat Feet, Ingrown Toenails, Bunions

MEDICATIONS

_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____
_____ Dosage _____

Allergies _____

Greenworx Printing 903-872-5922

Please give your insurance card and drivers license to the receptionist to be copied.

Insurance Information

Primary Insurance: _____

Policy # / Subscriber ID #: _____

Relationship: ( ) Self ( ) Spouse ( ) Other Relation _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Social Security #: _____

Secondary Insurance: _____

Member #/Subscriber ID #: _____

Relationship: ( ) Self ( ) Spouse ( ) Other Relation_____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Social Security #: _____

I acknowledge that the above is true to the best of my knowledge. 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) as I so chose, and understand the notice.

_____ _____

Printed Name Date

_____ _____

Signature Parent or Authorized Representative (if applicable)

<u>INSURANCE PATIENTS ONLY</u> – (Please initial one & Sign Below)

_____ I understand that even though I am paying my copay or towards my deductible today that my insurance is being billed. I understand that I still may receive a bill and any remaining balances will be my full responsibility.

(Even if I have a secondary insurance.)

_____ I understand that my insurance is Out-of-Network – and even though I am paying my copay or towards my deductible today that my insurance is being billed out of network and my coinsurance could be higher. I understand that I still may receive a bill and any remaining balances will be my full responsibility.

_____ I understand that even though I have insurance – I have decided to opt out and pay as a self-pay cash patient. I understand that my insurance WILL NOT be billed and fees for services rendered must be paid today.

_____ _____

Signature **Date**

<u>NO INSURANCE – CASH PATIENTS</u> – (Please initial If NO Insurance & Sign Below)

_____ I understand that I do not have any insurance and as a cash patient all fees must be paid today for services rendered.

_____ _____

Signature **Date**

FAMILY
FOOT & ANKLE
CENTERS

CORSICANA
3229 W. 7th Ave.
Corsicana, TX 75110
903-872-9910

ENNIS
601 S. Clay St. Ste. 105
Ennis, TX 75119
972-875-3668

WAXAHACHIE
1505 W Jefferson Ste.
Waxahachie, TX 75165
972-597-4132

Contact/Prescription Consent

We utilize both telephone and/or text appointment reminders a couple of days before your appointment. We also send all prescriptions electronically that views prescription history to help reduce drug to drug interactions. Prescriptions will be sent electronically to your pharmacy of choice.

You agree, in order for us to service our account or to collect any amounts you may owe,our organization's representatives, ancillary providers, HIPAA business associates, vendors,and representatives may contact you by telephone, including wireless telephone numbers,which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors and its debt Collection agents may contact me/us as described above.

_____ _____

Customer Signature Date