



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: | <input type="checkbox"/> Foot Burning | <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Seizure | <input type="checkbox"/> Loss of Balance | | |
| Skin: | <input type="checkbox"/> Rash | <input type="checkbox"/> Skin Sores | <input type="checkbox"/> Itching | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Toenail Changes | |
| Orthopedic: | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Weakness | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> 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

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Diabetes (Insulin) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes (No Insulin) | <input type="checkbox"/> Lung Disease (COPD) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis (A, B, C) | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Stroke (CVA) | <input type="checkbox"/> Anxiety / Depression | |

FINANCIAL POLICY

I give permission to Jeffrey S. Petty DPM, his associates or assistants 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. The only limitation to my financial liability for charges not paid by insurance occurs in the event of contractual limitations to the charged fees that have been agreed upon by Jeffrey S. Petty, DPM, PA and the insurance company. 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 _____

Allergies _____



FAMILY FOOT & ANKLE CENTERS

Name: _____

DOB: _____

Please Circle ALL Allergies:

CODEINE PENICILLIN SULFA TAPE LATEX CORTISONE IODINE SEASONAL

OTHER ALLERGIES: _____

• Do we have permission to look at your previous medication from other doctors and or pharmacies? _____ Yes _____ No

Signature

Date

**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)

INSURANCE PATIENTS ONLY - (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

NO INSURANCE - CASH PATIENTS - (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
600 Ferris Ave.
Waxahachie, TX 75165
972-597-4132

MEXIA
514 S. Bonham St., Ste D
Mexia, TX 76667
254-523-4803

Medical Financial Consent Form

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 the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency 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.

Borrower/Customer Signature

Date



FAMILY FOOT & ANKLE CENTERS

FINANCIAL AGREEMENT

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is furnished.
 - You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
 - For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is your responsibility to notify our front desk staff of any insurance or address changes.
3. You will be responsible for any charges that occur if we are not notified.

PATIENT AUTHORIZATION

I hereby authorize Dr. Petty/Dr. Mankerious to administer such medication or procedures as are necessary on the basis of findings in my case. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency or its intermediary any information needed for this or a related insurance claim. I request that payment of authorized benefits be made to **Corsicana Foot & Ankle/PMPT**, I agree to pay any charges incurred by me to **Corsicana Foot & Ankle/PMPT**. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ I authorize **Corsicana Foot & Ankle/PMPT** to submit insurance claims using my signature on file below.

_____ I authorize the release of any medical information necessary in order to process this assignment on this claim.

_____ I authorize payment of medical benefits to be paid directly to **Corsicana Foot & Ankle/PMPT** for services described on the claim form.

ALL CO-PAYS AND/OR CO-INSURANCES ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

I authorize Dr. Petty/Dr. Mankerious to release any medical or billing information necessary for treatment, payment, or healthcare operations to the following healthcare professions, family, and/or friends:

Name

Relationship

Name

Relationship

Name

Relationship

Patient Signature (or authorized representative)

Date