VASCULAR/NEROPATHY WORKSHEET -please circle your answer

1. Do you experience pain in your legs/feet when walking? YES/NO
   - If so, where does it hurt when you walk? THIGHS/KNEES/CALVES/FEET
2. Is the pain in your legs/feet relieved by rest? YES/NO
3. Do cuts in your arms/legs or hands/feet take a long time to heal? YES/NO
4. Have you noticed that less hair grows below your knees than above them? YES/NO
5. Do you have or have you had ulcers on your feet? YES/NO
6. Have you noticed that your feet feel cold even when the temperature is warm? YES/NO
7. Do you suffer from numbness, tingling or burning in your legs or arms? YES/NO
   - If so, where? ARMS/HANDS/BUTTOCKS/LEGS/FEET

PODIATRIC MEDICAL PARTNERS OF TEXAS, P.A. - NOTICE OF PRIVACY PRACTICES

WILLIAM C. ARRINGTON, D.P.M. AND ASSOCIATES ARE COMMITTED TO PROTECTING THE PRIVACY AND SECURITY OF INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION AND OTHER PROTECTED HEALTH INFORMATION OF A CONFIDENTIAL NATURE FOR THIS MEDICAL PRACTICE AS SET FORTH IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTACILY ACT ("HIPPA").

I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS "NOTICE OF PRIVACY PRACTICES".

PATIENT SIGNATURE_____ **DATE**_____

CONSENT FOR RELEASE OF INFORMATION & MEDICAL RECORDS

Date: ____/____/____

Patients Name: _____

SSN ____-____-____

I hereby give my permission for:

_____

Hospital/Physician/Insurance company

Address:

_____

Phone:_____ Fax:_____

TO RELEASE OR DISCLOSE TO:

Dr. William Arrington/Dr. Justin Wade/Dr. Matthew Britt @ Beltline/Wylie/Forney/Rowlett Foot & Ankle
1601 N. Beltline Rd. Suite A Mesquite, TX 75149 (Main office)
Ph: 972-288-7441 Fax: 972-289-8025

The following information:

_____

For period beginning:_____ and ending:_____.
This information will be used for:_____. I authorize this information to be release. This consent is subject to revocation at any time by me in writing.

Signature of patient/parent (if minor):_____ DATE: _____