TEXAS FOOT & ANKLE SPECIALISTS
A DIVISION OF STRIDE HEALTHCARE

Dr. William Arrington Dr. Justin Wade Dr. Rebekah Cherian Dr. Zachery Barnett

PATIENT INFORMATION_____DATE:_ _/_ _/_____

Name: Last_____ First_____Mi_____

Address_____ City_____ State_____ Zip_____

Sex M □ F □ Date of Birth____/____/_____ Age_____ SSN_____-_____-_____ Martial Status_____

Spouses Name _____ Spouse Employer_____

Home Phone_____ Cell phone_____ E-mail address _____

Referred By_____ **Primary Care Physician** _____ **Date Last Seen**_____

Pharmacy: _____ **Address** _____ **Phone**_____

EMERGENCY CONTACT INFORMATION_____

Name: Last_____ First_____ Relationship_____

Home Phone_____ Cell Phone_____

PATIENT EMPLOYER INFORMATION_____

Employer Name_____ Employer Phone_____

Address_____ City_____ State_____ Zip_____

POLICY HOLDER (GUARANTOR) INFORMATION_____

Name: Last_____ First _____ Date of Birth_____/_____/_____

Address_____ City_____ State_____ Zip_____

Phone_____ SSN_____-_____-_____ Relationship_____

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to pay directly to Dr. Arrington/Dr. Wade/Dr. Barnett the benefits and amount due and otherwise payable to me for their services, as described on the customary charges for those services. I acknowledge and understand that I am responsible for all of the charges for all services rendered to me or any member of my immediate family. Although I have requested the doctor to bill my insurance company in the case of surgery, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

MEDICARE

I hereby authorize my insurance company to pay directly to Dr. Arrington/Dr. Wade/Dr. Barnett the benefits and amounts due and otherwise payable to me for their services as described, but not to exceed the reasonable customary charges for those services. I understand that I am financially responsible for all remaining charges incurred, whether or not covered by said insurance.

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize Dr. Arrington/Dr. Wade/Dr. Barnett to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with any claims.

SIGNED_____ DATE_____

PATIENT MEDICAL HISTORY_____NAME:_____

Please circle any of the following conditions that you have or had:

Acne	Cataracts	Gout	Muscular Dystrophy
Anemia	Charcot foot	Heart Attack	Pulmonary Fibrosis
Ankle Swelling	Chemical Dependency	Heart Disease	Raynaud's
Anxiety	Chest Pain	Hepatitis A B C D E	Rheumatoid Arthritis
Arthritis	Circulatory Disorders	Hernia	Seizures
Artificial joint	COPD	High Blood Pressure	Shortness of Breath
replacement	CRPS/RSD	High Cholesterol	Squamous Cell Carcinoma
Asthma	Depression	Hyperthyroid	Stroke
Autoimmune dz	Diabetes	Hypothyroid	Tuberculosis
(HIV/AIDS)	Epilepsy	Kidney Disease	Warts
Basal Cell Carcinoma	Fibromyalgia	Liver Disease	Other:
Bleeding Disorders	GI Bleeding	Malignant Melanoma	
Cancer_____	GI reflux/GERD	Mitral Valve Prolapse	

ARE YOU DIABETIC? YES____ NO____ IF YES, LAST GLUCOSE READING_____ A1c_____

PAST SURGICAL HISTORY_ - please list procedure & date_____

_____

_____

_____

FAMILY MEDICAL HISTORY_____

Mother Alive? Yes____ No____ Past/Med Hx_____

Father Alive? Yes____ No____ Past/Med Hx_____

# of Brothers _____ PMH_____

# of Sisters _____ PMH_____

SOCIAL HISTORY_ - please circle one_____

·Single. Married (___years). Widowed. Separated. Divorced. # of Healthy Children____ # of Deceased Children _____

·Live with: Spouse. Family. Nursing Home. Assisted Living. Alone. Other_____

·Tobacco Use: Smoker. Smokes ____Packs A Day. Smokeless Tobacco. Non-Smoker. Quit ____ Years Ago. Smoked ____ years.

·Illicit Drug use.

·Exercise includes: None. Walking Every Day. Walking Occasionally. Jogging. Aerobic Activity ___ Times Per Week. Treadmill. Weight Lifting. Other_____

·Caffeine: YES____ NO____ ·Alcohol: YES____ NO____ If Yes, Daily or Occasionally.

·Do you follow any special diet: YES____ NO____ If Yes, Why_____

·Sleep Habits: Unremarkable. Patient has: Trouble Falling Asleep, Trouble Staying Asleep, Frequent Nighttime Urination, Daytime Drowsiness, Nightmares, and Restless Legs.

Height____ft _____in. Weight_____lbs. Shoe Size_____

Current Medications (If any)

1_____	4_____	7_____
2_____	5_____	8_____
3_____	6_____	9_____

Allergic To (Circle): Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia, Other_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Please complete the following to give consent for us to request record from any provider you list below (when needed) in regard to your continued medical care with Dr. Arrington/ Dr. Wade/ Dr. Cherian/ Dr. Barnett.

Date:_____ / _____ / _____

Patient Name:_____ Date of birth: _____ / _____ / _____ SSN:XXX-XX-_____

I hereby give permission for (name of any provider that you would give permission to send us records):

(Name of: Facility / Hospital / Physician / Insurance Company)

Address:_____ City:_____ St:_____Zip:_____

Phone #: _____ Fax#:_____ Contact Name (if you have one):_____

TO RELEASE OR DISCLOSE:

The following information:

(All medical records / Specific office visit notes / Diagnostic results / Lab results / etc.)

Beginning on date: ____ / ____ / ____ and ending on date: ____ / ____ / ____

TO:

Foot and Ankle Specialists – Offices of Dr. William Arrington / Dr. Justin Wade / Dr. Rebekah Cherian / Dr. Zach Barnett
Address (main office): 1601 N. Beltline Rd Ste. A Mesquite, TX 75149- Ph: 972-288-7441, Fax:833-916-2197

I authorize this information to be released, but this consent is subject to revocation at any time by me in writing.

Patient Signature (or parent if minor): _____ **Date**: _____ / _____ / _____

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Dr. William Arrington, Dr. Justin Wade, Dr. Rebekah Cherian, and Dr. Zach Barnett 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 Accountability Act (HIPAA).

I, _____, have received a copy of the office's Notice of Privacy Practices as required by law.

Patient Signature (or parent is a minor):_____ **Date**: _____ / _____ / _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:

____ Individual refused to sign.
____ An emergency situation prevented us from obtaining it.
___ Communication barrier.
____ Other (please specify): _____

VASCULAR / NEUROPATHY **PATIENT:** .

Please circle your answers:

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

CHIEF COMPLAINT / HISTORY OF PRESENT CONDITION .

Current foot problem(s):_____

_____

_____

Please circle all that apply →

COURSE

Intermittent / Constant

Progressive / Varied

LOCATION

left / right / foot / ankle / 1st toe

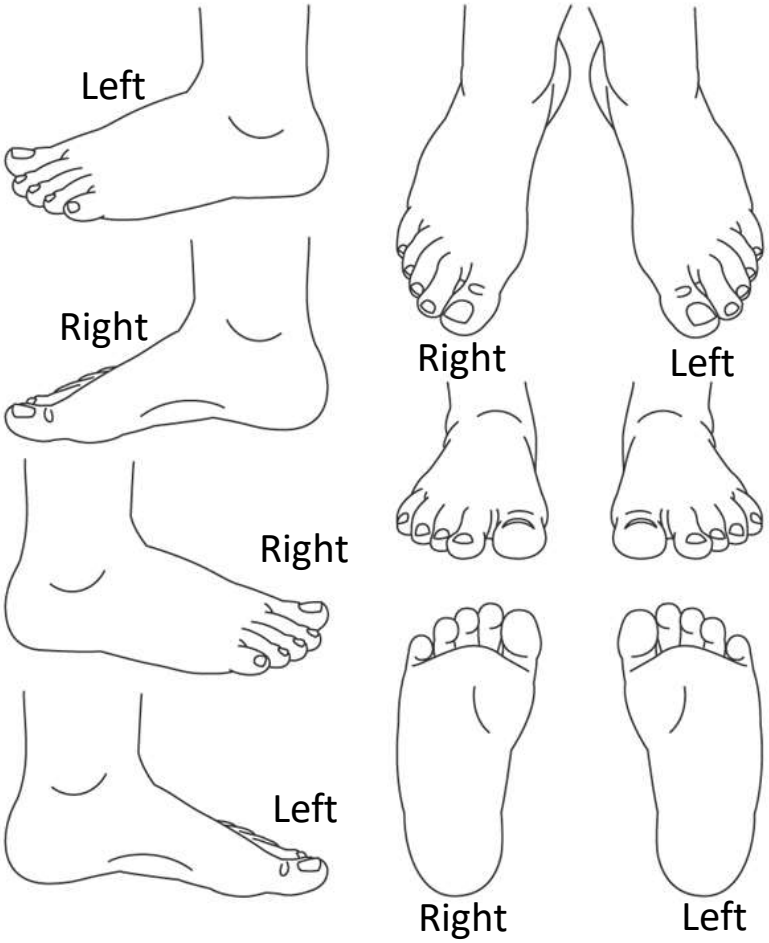
2nd toe / 3rd toe / 4th toe / 5th toe

NATURE

sharp / dull / achy / burning

stabbing / tingling / numbness

Please circle your problem areas on the diagram below:



Duration(how long have you had the problem):

_____

_____

_____

Onset(how did it start):

_____

_____

_____

Aggravating Factors(what makes it worse):

_____

_____

_____

Treatment(have any other treatments been done):

_____

_____

_____