PODIATRIC REGISTRATION AND HISTORY
North Texas Foot & Ankle, P.A.

1. PATIENT INFORMATION

Date ____________________
Patient ____________________
Address ____________________
____
City State Zip
Sex: ☐M ☐F Age ___ Birthdate ______________
☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Patient SS# ____________________
Occupation ____________________
Employer ____________________
Employer Address ____________________
Employer Phone ____________________
Spouse's Name ____________________
Birthdate ______________SS# ____________________
Occupation ____________________
Spouse's Employer ____________________
Whom may we thank for referring you? ______________
____
*Email Address: ____________________

*Email addresses are kept strictly private and are used for mailings of newsletters, discounts and reminders of appointments. Email addresses are not given out for distribution.

3. PHONE NUMBERS

Home ______________ Work ______________ Ext ______
Best time and place to reach you ______________

IN CASE OF EMERGENCY, CONTACT
Name ____________________ Relationship ______________
Home Phone ______________ Work Phone ______________

4. PODIATRIC HISTORY

What is the chief complaint for which you came to be treated?
(Include foot, ankle, knee, thigh, and hip complaints.)
____
____
____
Have you ever been to a Podiatrist before? ☐Yes ☐No
If yes, please list.
Name ____________________
Last visit ____________________
Is there any personal or family history of diabetes? ☐Yes ☐No
Your occupation ____________________
Cigarette/Tobacco use ____________________
Years smoked ____________________
Athletic activities in which you participate (please list and indicate frequency)
____
____
____

2. INSURANCE

Who is responsible for this account? ____________________
Relationship to Patient ____________________
Insurance Co. ____________________
Group # ____________________
Is patient covered by additional insurance? ☐Yes ☐No
Subscriber Name ____________________
Birthdate ______________ SS # ____________________
Relationship to Patient ____________________
Insurance Co. ____________________
Group # ____________________

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with ________________________ and assign directly to Dr. Hausenfluke all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature
______________ ______________
Relationship Date

MEDICARE AUTHORIZATION
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Hausenfluke for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________ ______________
Relationship Date

Please indicate which foot problems you now have or have had in the past.

Ankle Pain ....☐Yes ☐No
Athlete's Foot............................☐Yes ☐No
Bunions....................................☐Yes ☐No
Corns and Calluses ....☐Yes ☐No
Cramps or Numbness in ....☐Yes ☐No
Feet or Legs
Flat Feet...................................☐Yes ☐No
Foot or Leg Cramps..................☐Yes ☐No
Heel Pain ....☐Yes ☐No
Ingrown Toenails.......................☐Yes ☐No
Plantar Warts ....☐Yes ☐No
Swelling in Ankles or Feet ....☐Yes ☐No
Tired Feet.................................☐Yes ☐No

5. MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Ear Problems	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Diabetes	☐Yes ☐No	Epilepsy	☐Yes ☐No	Rash	☐Yes ☐No
Allergies to Anesthetics	☐Yes ☐No	Eye Problems	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Allergies to Medicine or Drugs	☐Yes ☐No	Fainting	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Anemia	☐Yes ☐No	Foot or Leg Cramps	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Angina	☐Yes ☐No	Gout	☐Yes ☐No	Special Diet	☐Yes ☐No
Arthritis	☐Yes ☐No	Headaches	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Heart Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Asthma	☐Yes ☐No	Hemophilia	☐Yes ☐No	Swelling in Ankles, Feet	☐Yes ☐No
Back Problems	☐Yes ☐No	Hepatitis or Jaundice	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Tired Feet	☐Yes ☐No
Cancer	☐Yes ☐No	Liver Disease	☐Yes ☐No	Kidney Problems	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chest Pain	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Ulcers	☐Yes ☐No
Chronic Diarrhea	☐Yes ☐No	Phlebitis	☐Yes ☐No	Varicose Veins	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Venereal Disease	☐Yes ☐No
				Weight Loss, unexplained	☐Yes ☐No

Surgeries you have had ______________________________

____

____

Hospitalization other than for the surgeries listed ______________________________

____

____

Family Physician ______________________________ Last visit date ______________

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐Yes ☐No

If yes, please explain ______________________________

____

____

6. MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins

____

____

____

Pharmacy Name(s)

____

Pharmacy Phone(s)

____

Do you take oral contraceptives? ☐Yes ☐No

Other ______________________________

7. ALLERGIES

☐Adhesive/Tape
☐Anticoagulant Therapy
☐Aspirin
☐Codeine
☐Demerol
☐Iodine
☐Local Anesthetics
☐Novocaine
☐Penicillin
☐Sea foods
☐Sulfa
☐Other: ______________________________

____

____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature ______________________________ Date ______________

New patients will need to be present 15 minutes prior to their appointment times to allow for paperwork.

Please bring drivers license and insurance card along with your co-pay. We accept cash and credit cards.