



**PATIENT REGISTRATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

ADDRESS 1: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

LANGUAGE: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

EMPLOYMENT STATUS:      EMPLOYED      UNEMPLOYED      STUDENT      RETIRED

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

**CONTACT INFORMATION**

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

**PRIMARY CARE / OTHER PHYSICIAN**

PRIMARY CARE (PCP) NAME: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ LAST VISIT WITH PCP: \_\_\_\_\_

**PHARMACY INFORMATION**

PHARMACY NAME: \_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_

PHARMACY LOCATION/INTERSECTION: \_\_\_\_\_

**YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT**

**By signing below, I attest that the information provided above is true and accurate.**

**Patient/Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**FINANCIAL POLICY:** Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

**DEDUCTIBLES & CO-INSURANCE:** If you have a high deductible plan, we may collect a deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

**SELF-PAY:** Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.

**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

**NO SHOW:** 24 hours notice is required for cancellation of your appointment and failure to do so will incur a **\$50** fee. Failure to provide **24 hours-notice** of a procedural visit will incur a **\$100** fee.

**SURGERY CANCELLATION:** Failure to provide **5 business days** notice of cancellation prior to scheduled surgery date will incur a **\$500** fee.

**BALANCES/COLLECTION FEES:** If balance is not collected within 30 days from the postmark date of a mailed statement, a **\$12** re-billing fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a **\$35** administrative fee will be added. We accept cash, checks, and all major credit cards.

**FMLA / DISABILITY / MEDICAL RECORDS:** Fees for medical records are as follows: **\$25** charge for completion of **FMLA and disability forms**; **\$25** fee for a copy of your **medical records** (pages 1-20), **plus an additional \$.50 per page** thereafter; **\$25** fee for digital x-ray copies on CD; **\$25** fee for other medical forms requested; Postage and delivery are at the expense of the patient and will also include a **\$15** administrative fee.

**PRIVACY POLICY:** I acknowledge that I have been able to view the NOTICE OF PRIVACY PRACTICES in the office of Dr. David Jenson. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice’s use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice, others, or myself.

**INFORMED CONSENT:** I understand that the information sent to me via email and/or text message from persons at JENSON Foot & Ankle Specialist will not be sent securely and will be unencrypted. I understand the risks associated with that; including but not limited to, that my PHI may be read by an unintended third party. I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via email and text message as is convenient or necessary for certain communication with staff members. I understand that JENSON Foot & Ankle Specialist, and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text. I further understand that I bear the risk.

**PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST:** The purpose of the disclosure notice is to inform you that JENSON Foot & Ankle Specialist has financial interests in Essential Imaging Center, Surgery Center of The Woodlands, and North Houston Medical Center. You have the right by law to choose the provider of your health care services. You will not be treated differently by your physician if you choose to obtain imaging services or have surgery at another facility. We welcome you as a patient and value our relationship with you.

**I have read and understand the above financial policy, privacy policy, informed consent statement, and physician disclosure of financial interest notice.**

**Patient/Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR TODAY'S VISIT					
REVIEW OF SYSTEMS					
CONSTITUTIONAL		MUSCULOSKELETAL		NEUROLOGICAL	
FEELING SICK	Y / N	LOW BACK PAIN	Y / N	DIZZY	Y / N
FATIGUE	Y / N	PAIN IN LEGS	Y / N	DISORIENTED	Y / N
FOOT PROBLEM RELIEVED WITH REST	Y / N	PAIN IN FEET	Y / N	BALANCE ISSUES	Y / N
FEVER	Y / N	JOINT PAIN	Y / N	HEADACHES	Y / N
EYES & EARS		BONE PAIN	Y / N	SEIZURES	Y / N
GLASSES/CONTACTS	Y / N	GENERAL MUSCLE PAIN / ACHE	Y / N	TREMORS	Y / N
EYE PAIN	Y / N	SWELLING IN LEGS	Y / N	FEET FALL ASLEEP OFTEN	Y / N
RINGING IN EARS	Y / N	SWELLING IN JOINTS	Y / N	NUMBNESS OR BURNING IN FEET	Y / N
CARDIOVASCULAR		STIFFNESS IN JOINTS	Y / N	CRAMPS WHEN WALKING	Y / N
SWELLING IN LEGS	Y / N	CHANGES IN GAIT (WALK)	Y / N	PAIN IN FEET, RESTING	Y / N
VARICOSE VEINS	Y / N	DIFFICULTY CLIMBING STAIRS	Y / N	PAIN IN FEET, ALL THE TIME	Y / N
LEG CRAMPS WITH REST	Y / N	LOSS OF STRENGTH IN LEGS	Y / N	SHOOTING PAIN IN LEGS	Y / N
LEG CRAMPS WITH WALKING	Y / N	RIGIDITY IN LEGS	Y / N	LEG PARALYSIS	Y / N
COLD FEET	Y / N	LIMP WHEN WALKING	Y / N	PSYCHIATRIC	
RESPIRATORY		INTEGUMENTARY		PSYCHIATRIC ILLNESSES	Y / N
CHEST PAINS	Y / N	SKIN PROBLEMS	Y / N	DEPRESSION	Y / N
DIFFICULTY BREATHING	Y / N	SUN SENSITIVITY	Y / N	BI-POLAR	Y / N
SHORTNESS OF BREATH	Y / N	SKIN RASHES	Y / N	ANXIETY	Y / N
GASTROINTESTINAL		WARTS ON FEET	Y / N	MOOD SWINGS	Y / N
LOSS/INCREASE OF APPETITE	Y / N	MOLES, LUMPS, OR BUMPS	Y / N	UNDER STRESS	Y / N
STOMACH ULCERS	Y / N	DRY SKIN	Y / N	ENDOCRINE	
FREQUENT HEARTBURN	Y / N	OPEN SORES	Y / N	LOST / GAINED WEIGHT	Y / N
STOMACH PROBLEMS	Y / N	SKIN DISCOLORATIONS	Y / N	EXCESSIVE THIRST	Y / N
BLOODY OR DARK STOOL	Y / N	CORNS AND CALLOUSES	Y / N	NIGHT SWEATS	Y / N
GASTROURINARY		THICK NAILS	Y / N	SWOLLEN GLANDS	Y / N
FREQUENT URINATION	Y / N	DEFORMED NAILS	Y / N	HEMATOLOGY	
PAIN WITH URINATION	Y / N	INGROWN NAILS	Y / N	BRUISE EASILY	Y / N
BURNING WITH URINATION	Y / N			IMMUNOLOGY	
BLOOD IN URINE	Y / N			SLOW HEALING WOUNDS	Y / N

PATIENT SIGNATURE:



LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

PAST MEDICAL, FAMILY, SOCIAL HISTORY				
LOWER EXTREMITY		PAST MEDICAL HISTORY (CONTINUED)		FAMILIAL DISEASES
ANKLE PAIN	Y / N	<b>PREVIOUS SURGERIES:</b>	<b>DATE/YEAR</b>	CARDIOVASCULAR DISEASE Y / N
ATHLETE'S FOOT	Y / N	_____	_____	HEART ATTACK Y / N
BUNION	Y / N	_____	_____	STROKE Y / N
CORNS & CALLOUSES	Y / N	_____	_____	HIGH BLOOD PRESSURE Y / N
CRAMPS IN LEGS / FEET	Y / N	_____	_____	ELEVATED CHOLESTEROL Y / N
FLAT FEET	Y / N	_____	_____	DIABETES Y / N
HEEL PAIN	Y / N	ALLERGIES		ASTHMA / HAY FEVER Y / N
INGROWN TOENAILS	Y / N	_____	_____	CONGENITAL HEART DISEASE Y / N
NUMBNESS IN LEGS / FEET	Y / N	_____	_____	GLAUCOMA Y / N
PLANTAR WARTS	Y / N	_____	_____	OBESITY Y / N
SWELLING IN ANKLES / FEET	Y / N	_____	_____	LEUKEMIA/CANCER Y / N
PAST MEDICAL HISTORY		MEDICATIONS		OTHER: _____
ANEMIA	Y / N	_____	_____	SOCIAL HISTORY
ANESTHETIC REACTION	Y / N	_____	_____	EXERCISE Y / N
ARTHRITIS	Y / N	_____	_____	SEXUALLY ACTIVE Y / N
ASTHMA	Y / N	_____	_____	PREGNANT Y / N
BLEEDING DISORDERS	Y / N	_____	_____	TOBACCO USE Y / N
CANCER: _____	Y / N	FAMILY HISTORY		MARIJUANA USE Y / N
CIRCULATION PROBLEMS	Y / N	FATHER		RECREATIONAL DRUG USE Y / N
DIABETES TYPE: I II	Y / N	ALIVE / DECEASED (CAUSE: _____)		ALCOHOL USE Y / N
STROKE	Y / N	ILLNESSES: _____		CAFFEINE Y / N
EPILEPSY	Y / N	_____		LEVEL OF EDUCATION: _____
GOUT	Y / N	GENERAL HEALTH: EXCELLENT / GOOD / FAIR / POOR		_____
HEART DISEASE	Y / N	MOTHER		OCCUPATION: _____
HEPTATITIS	Y / N	ALIVE / DECEASED (CAUSE: _____)		OTHER
HIGH BLOOD PRESSURE	Y / N	ILLNESSES: _____		
HIGH CHOLESTEROL	Y / N	_____		
HIV/AIDS	Y / N	GENERAL HEALTH: EXCELLENT / GOOD / FAIR / POOR		
KIDNEY DISEASE	Y / N	SIBLING(S)		
LIVER DISEASE	Y / N	NUMBER OF SIBLINGS _____		
MITRAL VALVE PROLAPSE	Y / N	ILLNESSES: _____		
NAIL DISORDERS	Y / N	_____		
NERVE DISORDERS	Y / N	_____		
PHLEBITIS	Y / N	_____		
PULMONARY DISEASE	Y / N	_____		
SKIN PROBLEMS	Y / N	GENERAL HEALTH: EXCELLENT / GOOD / FAIR / POOR		

PATIENT SIGNATURE:





**RELEASE OF MEDICAL RECORDS**

(For immediate family only)

PATIENT NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I, the above patient, give permission to the office of David Jenson DPM, to provide any information regarding my medical records, including but not limited to, office notes, x-rays, lab results and billing information to the following recipients: (if no release is permitted, circle N/A)

N/A

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

According to Health and Human Services, this release does not limit our ability to send your medical records to covered entities for treatment, payment, or health care operations. This includes, but is not limited to, sending information to your pharmacy for prescription orders, communicating with your insurance plan to reimburse your charges, and disclosing with appropriate legal requests.

To make any changes to your release, please submit your request in writing to our office. Record requests may take up to 7-10 business days to complete and may be subject to a fee.

By signing below, you state you understand the release notice above and have opted to release or not release your medical records from our office.

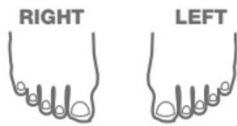
Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_



CLINIC INFORMATION		PATIENT INFORMATION	
<b>Dr. Name:</b> Dr. David Jenson, DPM, PA		<b>Patient Name:</b>	
<b>Address:</b> 111 Vision Park Blvd., #240, The Woodlands, TX. 77384		<b>Signature:</b>	
<b>Phone:</b> (936) 273-6000	<b>Fax:</b> (936) 273-6022	<b>Date:</b>	

Please indicate if you have any of the following symptoms:

**Pain:** Yes No



**RIGHT**



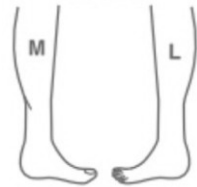
**LEFT**



**RIGHT**



**LEFT**



Do you take a daily Multi-Vitamin?

Yes No

### Prior Foot Problems

Previous amputation of leg or portion of foot? \_\_\_\_\_ Yes No  
 Previous foot ulcer? If Yes, Date: \_\_ / \_\_ / \_\_ \_\_\_\_\_ Yes No  
 Do you have a reduced sensation in your feet? \_\_\_\_\_ Yes No

### Current Foot Problems

Ulcer, sore or blister on your foot at this time? \_\_\_\_\_ Yes No  
 L0.89 (Open/Infected Sores), L02.612 (Abscesses), E11.621 (Diabetic Ulcer)  
 Pain or cramping in your feet when you walk? \_\_\_\_\_ Yes No  
 M00.87 (Joint Infections)  
 Do you have redness in your right foot/lower limb? \_\_\_\_\_ Yes No  
 L0.115 (Cellulitis of right lower limb)  
 Do you have redness in your left foot/lower limb? \_\_\_\_\_ Yes No  
 L0.116 (Cellulitis of left lower limb)

### Podiatry (Foot Specialist) Follow-Up

Have you seen a podiatrist (foot specialist) in the past 6 months? If yes, date of last visit: \_\_ / \_\_ / \_\_ \_\_\_\_\_ Yes No  
 Name of doctor: \_\_\_\_\_

### Other Foot Problems

Do you currently have athlete's feet? \_\_\_\_\_ Yes No  
 (Burning, itching, or redness) B35.5 (Athletes Feet)  
 Do you have an ingrown toenail that is causing pain? \_\_\_\_\_ Yes No  
 L60 (Ingrown Toenail)  
 Do you have spongy nails / nail fungus? \_\_\_\_\_ Yes No  
 Do you have any warts on your feet? \_\_\_\_\_ Yes No



**YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT AND CONSENT TO TREAT:**

**You have the right to:**

- Receive clear and accurate information about your benefits rights and responsibilities, and information on all of these services offered to you
- Be treated with respect and dignity
- Your privacy, and that your personal health information be kept secure and confidential.
- Be involved with the doctor and other health care professionals in the decision making process regarding your health care.
- Have a clear and open talk with your health care professional about appropriate care for your condition regardless of cost or whether it is covered by your health plan benefits.
- Refuse treatment and be informed of the probable consequences of your actions.
- Receive appropriate information so that you may give informed, voluntary consent to participate in research.
- Have your guardian, next of kin, or legally authorized person exercise your rights on your behalf if your medical conditions make you incapable of understanding or exercising your rights.
- Receive advice or assistance in prompt, courteous, and responsible manner.
- Be given the first name of any staff member involved in your case and speaking with their immediate supervisor if desired.
- Make a written or verbal suggestion or complaint about the care you receive.

**You have responsibility to:**

- Give patient identification and medical information, to the best of your ability, so that your physician can properly care for you.
- Follow the prescribed medical plan and health care instructions that you have agreed upon with your doctor.
- To the best of your ability, work with your doctor to be aware of and understand your health problems, and participate in developing your health care treatment goals.
- Keep you appointments, or tell the doctor ahead of time if you will be late or need to cancel.
- Pay any applicable co-pay, co-insurance, and deductibles at the time you receive service.
- Understand what medications you are taking and whether follow-up care is needed.
- Treat those caring for you with respect and courtesy.
- Express your opinions, concerns, or complaints in a constructive manner to appropriate people.

**CONSENT FOR MEDICAL TREATMENT:**

By signing below, I acknowledge that I voluntarily consent to medical treatment and procedures that may be performed on me during all healthcare visits now and in the future that is deemed medically necessary in order to treat the condition and/or conditions by the Dr. David Jenson and this includes, but is not limited to medical treatment, physical therapy, surgical care, x-ray, test, medications, laboratory test and/or other serves.

***I am aware of my right and responsibilities and consent for treatment.***

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_