PODIATRIC HISTORY AND PHYSICAL EXAMINATION

CHIEF COMPLAINT: _____

Other _____

HPI:

Onset, when did problem start? _____
Type of pain, what makes it worse? _____
What relieves? _____
Severity, (awaken from sleep?) _____
Home treatment: _____
Professional treatment: _____

PMH:

Foot surgeries: _____
Other surgeries: _____
Serious illness: _____
Family history of diabetes, stroke, hypertension, rheumatoid arthritis, gout, cancer? _____
Immunizations, Tetanus: _____
History of sexually transmitted disease, (AIDS, hepatitis.) _____
Psychiatric history: _____
Blood transfusions, year: _____

MEDICATIONS : _____

DRUG ALLERGIES: _____

SOCIAL AND FAMILY:

Occupation: _____
Parents alive? Cause of death? Foot problems? _____
Siblings alive? Cause of death? Foot problems? _____
Children: Foot problems? _____
Tobacco? Alcohol? _____

REVIEW OF SYSTEMS:

General: fever, weight loss, gain, night sweats? _____
Dermatological: rashes, itching, skin growths, hair loss? _____
GI: heartburn, abdominal pain, loss of appetite, hurt to swallow food, food gets stuck, blood in stools, black stool, changes in bowel habits, diarrhea, constipation, nausea? _____
Pulmonary: cough, wheeze, shortness of breath? _____
Cardiac: palpitations, chest pain, dyspnea on exertion? _____
Neurological: Dizziness, headache, visual problems, loss of consciousness, numbness, tingling, loss of strength? _____
Psychiatric: depression, sadness? _____
Genitourinary: painful urination, urinary frequency, incomplete urinary emptying, nocturia, abnormal discharge? _____
ENT: ringing of ears, hearing loss, sore throat, nasal discharge, runny nose, hoarse voice, seasonal allergies? _____
Musculoskeletal: other bone or joint pains?, exercise regularly? Any problems while exercising? _____

PODIATRIC PHYSICAL EXAM:

Height_____ Weight_____ B/P_____ Pulse_____ Resp_____ Shoe size_____

VASCULAR: _____

DERM: _____
NEURO: _____

MUSCULOSKELETAL: _____

RADIOLOGICAL: _____

DIAGNOSIS: _____

TREATMENT PLAN: _____

Advanced Foot & Ankle Center of North Texas
Welcome to Our Office!

Patient Name: _____ DOB: _____ Age: _____

Address: _____

City, State, & Zip: _____

Cell Phone: _____ Home Phone: _____

SS #: _____ Marital Status: S M W D

Email address: _____

Employer: _____ Business phone: _____

If patient is a student or minor add parental information, otherwise please add spouse's information:

Parent/Spouse: _____ Phone: _____

Employer: _____ Phone: _____

Family Physician: _____ Phone: _____

I will be paying today by: Cash ____ Credit Card ____ Check ____

Whom may we thank for referring you to our office? _____

Internet: Our Website __ Google __ Yahoo! __ Facebook __ Twitter ___ Other ____

Primary Insurance: _____

Name of Policy Holder: _____ Date of Birth: _____

Secondary Insurance: _____

Name of Policy Holder: _____

Nearest relative not living with you: _____

Address: _____ Phone: _____

Nature of foot/ankle complaint: _____

I hereby give permission to the doctors and staff of Advanced Foot & Ankle Center of North Texas to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my foot and/or ankle condition.

_____ _____

Date Signature (parent if minor child)

Advanced Foot & Ankle Center of North Texas

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTORS OF THE ADVANCED FOOT & ANKLE CENTER OF NORTH TEXAS THE BENEFITS AND AMOUNTS DUE AND OTHERWISE PAYABLE TO THEM FOR THEIR SERVICES, BUT NOT TO EXCEED THE REASONABLE AND 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, I clearly understand that it is still my responsibility to make sure that 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.

_____ _____

Date Signature (Parent if minor child)

AUTHORIZATION TO RELEASE INFORMATION

i, _____ do hereby authorize the doctors and staff of Advanced Foot & Ankle Center of North Texas to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with any claims.

_____ _____

Date Signature (Parent if minor child)

MEDICARE ASSIGNMENT OF BENEFITS

i, _____ do hereby authorize MEDICARE to pay directly to the doctors of the Advanced Foot & Ankle Center of North Texas the benefits and amounts due and otherwise payable to me for services rendered, but not to exceed the reasonable and customary charges for these services.

I understand that I am financially responsible for all remaining charges incurred whether or not covered by said insurance.

_____ _____

Date Signature (Parent if minor child)

Advanced Foot & Ankle Center of North Texas

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advanced by our staff. We accept cash, checks, American Express, MasterCard, Visa, and Discovery Card. We will file insurance claims for all of our SURGERY and PPO patients only. However, we will be happy to help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to the companies which pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the servies are rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

_____ _____

Date Signature (Parent if minor child)