**PODIATRIC HISTORY AND PHYSICAL EXAMINATION**

**CHIEF COMPLAINT:**


**HPI:**
- Onset, when did problem start?
- Type of pain, what makes it worse?
- What relieves?
- Severity, (awakened 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, hard 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:**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>B/P</th>
<th>Pulse</th>
<th>Resp</th>
<th>Shoe size</th>
</tr>
</thead>
</table>

**VASCULAR:**

**DERM:**

**NEURO:**

**MUSCULOSKELETAL:**

**RADIOLOGICAL:**

**DIAGNOSIS:**

**TREATMENT PLAN:**
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)

__________________________________________
Date

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

__________________________________________  ______________________________
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

__________________________________________  ______________________________
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 advance 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 services 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)