PATIENT INFORMATION

Please Print and Fax to 713-862-8328

Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Email Address: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Sex: M F Age: _____ Height: _____ Weight: _____ Marital Status: S M D W

Drivers License #: _____ SS #: _____

In case of emergency, contact whom?: _____

Relation: _____ Phone: _____

Medical Information

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Disease	❑	❑	Diabetes	❑	❑	Cholesterol
❑	❑	Arthritis	❑	❑	High Blood Pressure	❑	❑	HIV Positive

Shoe Size: _____ Medication List: _____

_____

Drug Allergies: _____

Chief Complaint or Problem: _____

_____

Date Symptoms Began / Injury Occurred: _____

Family Physician: _____ Phone #: _____

Address: _____ City, State, Zip: _____

May we send a copy of your foot evaluation to him / her for your medical records? ❑ Yes ❑ No

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

About Your Insurance

Primary Insurance: _____	Secondary Insurance: _____
Ins. Co. Phone #: _____	Ins. Co. Phone #: _____
Patient Relationship to Insured: Self / Spouse / Child / Other	Patient Relationship to Insured: Self / Spouse / Child / Other
Effective Date of Insurance: _____	Effective Date of Insurance: _____
Policy Holder's Name: _____	Insured's Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Insured's Employer: _____	Insured's Employer: _____
Insured's Date of Birth: _____	Insured's Date of Birth: _____
Insured's Phone #: _____	Insured's Phone #: _____
Policy # / Group ID #: _____	Policy # / Group ID #: _____
Insured's Social Security #: _____	Insured's Social Security #: _____

I hereby grant permission to Diagnostic Foot Specialists to examine and treat my feet and/or ankles. I also agree that the above information is true and correct.

Signed: _____ **Date:** _____ **Signature for minor:** _____

I authorize the release of any medical information allowed by HIPAA rules and regulations necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignments.

Signed: _____ **Date:** _____