Welcome to Our Practice

Name ______________________ Last First M.I. Social Security # ____________ Birthdate ________

Gender M F (please circle) Home Phone ____________ Alt. Phone ____________ Occupation ____________

Address ____________ Zip ____________ City ____________ State ____________

E-Mail ____________ Whom may we thank for referring you? ____________

SPOUSE ______________________ Last First M.I. Status Married Divorced Widowed Single Life Partner Minor (please circle)

Primary Insurance Information

Plan Name ____________ Policy # ____________ Group # ____________

Are you the policy holder? Yes No If "No" Policy Holders Name DOB

Secondary Insurance Information

Plan Name ____________ Policy # ____________ Group # ____________

Are you the policy holder? Yes No If "No" Policy Holders Name DOB

Insurance Assignment and Releases

I certify that I have coverage with the above listed insurances and assign Directly to Dr. David S. Jenson, DPM 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 authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and my disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is completed.

I, the above patient, acknowledge that I have been able to view the NOTICE OF PRIVACY PRACTICES. I have have alos 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.

In Case of Emergency

Name ____________ Relationship ____________ Phone ____________

Podiatric History

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh and hip complaints)

____

____

____

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

Y	N	Ankle Pain
Y	N	Athlete's Foot
Y	N	Bunions
Y	N	Corns and Calluses
Y	N	Cramps or Numbness in Feet or Legs
Y	N	Flat Feet
Y	N	Foot or Leg Cramps
Y	N	Heel Pain
Y	N	Ingrown Toenails
Y	N	Plantar Warts
Y	N	Swelling of Ankles or Feet
Y	N	Tired Feet

Social History

Y	N	Tobacco Use
Y	N	Alcohol Use
Y	N	Drug Use
Y	N	Caffeine Use
Y	N	Good Exercise Habits

Are you Diabetic?

YES Type ____________ No

Past Medical History

Y	N	Anemia
Y	N	Anesthetic Reaction
Y	N	Arthritis
Y	N	Asthma
Y	N	Bleeding Disorders
Y	N	Cancer
Y	N	Circulation Problems
Y	N	Stroke
Y	N	Epilepsy
Y	N	Foot Problems
Y	N	Gout
Y	N	Heart Disease
Y	N	Hepatitis
Y	N	High Blood Pressure
Y	N	High Cholesterol
Y	N	HIV/AIDS
Y	N	Injury/Trauma - Major
Y	N	Kidney Disease
Y	N	Liver Disease
Y	N	Mitral Valve Porlapse
Y	N	Nail Disorders
Y	N	Nerve Disorders
Y	N	Obesity
Y	N	Phlebitis
Y	N	Pulmonary Disease
Y	N	STD
Y	N	Skin Problems

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of patient/guardian ____________ Printed name ____________

Please complete other side

CONSTITUTIONAL

Question	Answer
Are you feeling good?	YES NO
Do you feel fatigue during the day?	YES NO
Is your foot problem relieved by ceasing daily activities?	YES NO
Do you have a fever?	YES NO

EYES & EARS

Question	Answer
Do you wear glasses or contacts?	YES NO
Do you have eye pain?	YES NO
Do you have ringing in your ears?	YES NO

CARDIOVASCULAR

Question	Answer
Do you have swelling of both legs?	YES NO
Do you have varicose veins?	YES NO
Do you have cramping in your legs at night or at rest?	YES NO
Do you have cramping in your legs when walking?	YES NO
Do your feet feel especially cold?	YES NO

RESPIRATORY

Question	Answer
Do you have chest pain?	YES NO
Do you have difficulty breathing?	YES NO
Do you have shortness of breath?	YES NO

GASTROINTESTINAL

Question	Answer
Do you have a loss/increase of appetite?	YES NO
Do you have stomach ulcers?	YES NO
Do you have frequent heartburn?	YES NO
Does aspirin cause your stomach problems?	YES NO
Do you have bloody or dark stools?	YES NO

GENITOURINARY

Question	Answer
Do you have frequent urination?	YES NO
Do you have pain with urination?	YES NO
Do you have burning with urination?	YES NO
Have you noticed blood in your urine?	YES NO

PLEASE LIST ALL PREVIOUS SURGERIES YOU HAVE HAD

MUSCULOSKELETAL

Question	Answer
Do you have lower back pain?	YES NO
Do you have pain in your legs?	YES NO
Do you have pain in your foot or feet?	YES NO
Do you have joint pain?	YES NO
Do you have bone pain?	YES NO
Do you have general muscle aches or pain?	YES NO
Have you had swelling in your legs?	YES NO
Have you had joint swelling?	YES NO
Do you have joint stiffness?	YES NO
Have you noticed a change in the way you walk?	YES NO
Do you legs cause difficulty in climbing stairs?	YES NO
Are you experiencing any loss of strength in your legs?	YES NO
Have you felt rigidity in your legs?	YES NO
Do you limp when you walk?	YES NO
Do your shoes wear out relatively quickly or unevenly?	YES NO

INTEGUMENTARY

Question	Answer
Do you have any skin problems?	YES NO
Do you have sun sensitivity?	YES NO
Do you have any skin rashes?	YES NO
Do you have any warts on your feet?	YES NO
Do you have any moles, lumps or bumps?	YES NO
Do you have dry Skin?	YES NO
Do you have any open sores?	YES NO
Do you have any skin discolorations?	YES NO
Do you calluses or corns?	YES NO
Do you have thick nails?	YES NO
Are your nails deformed?	YES NO
Are your nails ingrown	YES NO

PLEASE LIST ALL CURRENT MEDICATIONS YOU TAKE AND THEIR DOSAGE

NEUROLOGICAL

Question	Answer
Do you get dizzy?	YES NO
Do you get disoriented?	YES NO
Do you have problems keeping your balance?	YES NO
Do you often get headaches?	YES NO
Do you have seizures?	YES NO
Do you get tremors?	YES NO
Do your legs feel like they are falling asleep often?	YES NO
Do you have numbness in your legs?	YES NO
Do you have burning in your legs?	YES NO
Do you have cramping in your legs when walking?	YES NO
Do you have pain in your legs while at rest?	YES NO
Do you have pain in your legs all the time?	YES NO
Do you have shooting pain in your lower extremities?	YES NO
Do you have leg paralysis?	YES NO
Do your shoes wear out relatively quickly or unevenly?	YES NO

PSYCHIATRIC

Question	Answer
Do you have any psychiatic problems?	YES NO
Do you have mood swings?	YES NO
Are you under stress?	YES NO

ENDOCRINE

Question	Answer
Have you lost/gained weight over the last several months?	YES NO
Are you excessively thirsty?	YES NO
Do you have bad breath?	YES NO
Do you have night sweats?	YES NO
Do you have swollen glands?	YES NO

HEMATOLOGIC/LYMPHATIC

Question	Answer
Do you bruise easily?	YES NO

ALLERGIC/IMMUNOLOGIC

Question	Answer
If you get cut, does it take long to heal?	YES NO

Please list all allergies

David S. Jenson, DPM, PA
111 Vision Park Blvd Ste 240
The Woodlands, TX 77384
(P) 936.273.6000 – (F) 936.273.6022

Initial Pain Assessment Form
(Please fill out as much as possible)

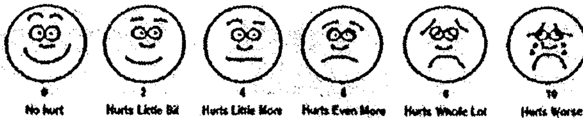
Name: ____________________DOB:_________ WT: _____ HT: ______

Please list any medication Allergies________________________________

Primary Care Physician Name and phone number ____

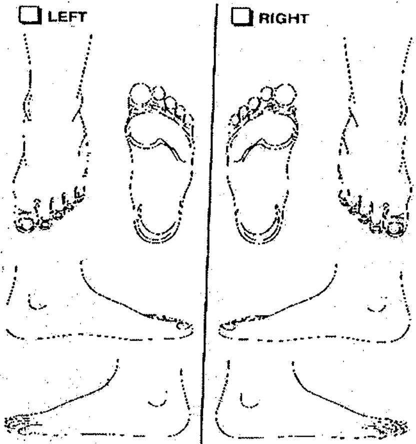
Date: ________________________

1.Which face shows how much you hurt now?
Put an "X" on the face.



If you have no pain, stop here.
If you have pain, answer questions 2 through 12.

2. Where is your pain?
Mark the areas on your body where you feel pain with "X"s.



3. Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Other		

4. Circle one: Occasional Continuous

5. Circle the time of day your pain is the worst.
(More than one time may be selected.)

Morning Afternoon
Evening Nighttime

6. What makes your pain *better?* ______________________________

7. What makes your pain *worse?* ______________________________

8. What treatment or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) ______________________ Treatment or Medicine (include dose)	No Relief	0	1	2	3	4	5	6	7	8	10	Complete Relief
b) ______________________ Treatment or Medicine (include dose)	No Relief	0	1	2	3	4	5	6	7	8	10	Complete Relief

9. Does your pain make it harder for you to: (circle all that apply)
Walk Sleep Sit Work Enjoy Life Eat Be Active Be with family or friends

10. What other problems are you having? (circle all that apply)
Constipation Dry Mouth Sleepiness Nausea / Vomiting
Other symptoms ____

11. What is your goal for pain control (pain intensity and goals related to activities / quality of life)?

____

12. Do you have any other comments to share with us regarding your pain?

____

Family Medical History

Father:

☐ Alive

My father's general health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health: ______________________________

☐ Deceased ☐ Age at death __________

Cause of death: ______________________________

Mother:

☐ Alive

My mother's general health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health: ______________________________

☐ Deceased ☐ Age at death __________

Cause of death: ______________________________

Siblings:

Number of brothers _______ Number of sisters _______

Health problems ______________________________

Familial Diseases

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave other blank)

Please list relative affected.

- ☐ Heart attack ____________________
- ☐ Stroke ____________________
- ☐ High blood pressure ____________________
- ☐ Elevated cholesterol ____________________
- ☐ Diabetes ____________________
- ☐ Asthma or hay fever ____________________
- ☐ Congenital heart disease ____________________
- ☐ Heart operations ____________________
- ☐ Glaucoma ____________________
- ☐ Obesity ____________________
- ☐ Leukemia or cancer ____________________

Comments: ______________________________

____

____

____

David S. Jenson, DPM
111 Vision Park Blvd Ste 240
The Woodlands, Texas 77384

RELEASE OF MEDICAL RECORDS

(For Immediate family only)

Please Print

Patient Name: ______________________________

Date: ______________________________

DOB: ______________________________

I, the above patient, give permission to the office of Dr. David S. Jenson, 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:

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

If there is no one you wish to receive your information please mark a line through this page.

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.

Please be aware this release is void 180 days after the date signed and you may be asked for your release in the future for any of the above noted information.

______________________________ ______________________________
Patient Signature Date

David S. Jenson, DPM
111 Vision Park Blvd
Suite 240
The Woodlands, TX 77384

Notice of Privacy Practices

Patient Name (please print):____

I, the above patient, acknowledge that I have been able to view the Notice of Privacy Practices posted in the office of Dr. David S. 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.

_________________________________ _______________________________

Signature Date

Disclosure:

I am aware that Dr. David S Jenson, DPM, has ownership interest in the following; Vision Park Premier Imaging Center, First Surgical Woodlands, Magna Surgery Center, Southwest Freeway Surgical Center, and ICON Biologics.

_________________________________ _______________________________

Signature Date

Dr. David Jenson, DPM, PA
111 Vision Park Blvd Ste 240
The Woodlands, TX 77384
(P) 936-273-6000 (F) 936-273-6022

Fee Policy

Effective January 1, 2009:

All no shows and cancellations with less than a 24 hour notification will be subject to a $25 fee which will be applied to your account and MUST be paid before your next visit.

____

Patient Signature

Your Rights and Responsibilities as a Patient

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 a prompt, courteous, and responsible manner.
- Be given the first name of any staff member involved in your case and speak with their immediate supervisor if desired.
- Make a written or verbal suggestion or complaint about the care you receive.

You have the 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 your appointments, or tell the doctor ahead of time if you will late or need to cancel.
- Pay any applicable co-pay, co-insurance, and deductibles at the time you receive service.
- Understand what medication 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 the appropriate people.

I am aware of my rights and responsibilities.

______________________________ __________________

Signature Date

____

Printed name

111 VISION PARK BLVD.
SUITE 240
THE WOODLANDS, TX 77384

4120 Southwest Freeway
SUITE 2230
HOUSTON, TX 77027

TELE: 936.273.6000

FAX: 936.273.6022

Surgery Cancellation Policies

Scheduling of your out-patient surgery requires a coordinated effort of multiple people beginning with your doctor and including his nursing and administrative staff. Evaluation at the surgery center or hospital by administrative, nursing, and anesthesia staff is also a time consuming and expensive period. Authorization by your insurance carrier must be obtained and the appropriate hardware for your operation must be ordered and made available for the time of your surgery. A tremendous amount of work takes place in preparation for your operation.

Patients are often asked to wait several months for their surgeries because of the large volume of patients treated. Many of these patients would like to have their surgeries moved to a closer date if possible.

Cancellation of surgery is sometimes unavoidable due to medical problems or significant conflicts which cannot be avoided. These cancellations, however, can result in unused operative time. Potentially productive time by the physician goes unused despite the tremendous amount of work required in preparation for that particular operation. Other patients who could have benefited from that operative time cannot do so unless the operative time is made available soon enough.

Therefore, the following fees will be assessed:

Cancellations less than two (2) weeks before surgery will be charged a $500.00 fee.

Failure to appear the day of surgery (no show) will result in a $750.00 fee.

Patient's Name:______________________________

Signature:______________________________

Date:______________________________

Patient Requested Forms

Because of increased cost for our transcription, proofreading, and mailing, the following costs have been instituted:

Letters of Medical Necessity.. $20.00

Original Disability Packets... $40.00

Updated Disability Forms.. $10.00

Patient's Signature ______________________________

Printed Name ______________________________

Date ______________