ARLINGTON / MANSFIELD
Foot & Ankle Centers, PA

JOHN R. LANDRY, D.P.M.
JOE T. SOUTHERLAND, D.P.M.
RYAN N. LAWRENCE, D.P.M.
R. DAVID WARREN, D.P.M.
LINNIE V. RABJOHN, D.P.M.

PATIENT INFORMATION

Date ______________________

Patient Name ______________________ Date of Birth __________ Sex: M F

Marital Status: M S W D Social Security # _____-_____-_____

Address ______________________ City ______________________

State __________ Zip __________-__________ Telephone (Home) ______________________

Telephone (Cell) ______________________ Email ______________________

Place of Employment ______________________

Business Address ______________________ Telephone (Work) ______________________

Spouse/Parent ______________________ Social Security # _____-_____-_____

Address (**if different than above**) ______________________

City __________ State __________ Zip __________-__________ Telephone (Home) ______________________

Place of Employment ______________________

Occupation ______________________ Telephone (Work) ______________________

Person Who Does Not Live With You To Contact In Emergency

Name ______________________ Phone # ______________________ Relationship __________

Address ______________________ City __________ State __________ Zip __________

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

☐ Friend/Family ☐ Internet ☐ Yellow Pages ☐ Doctor ______________________
Please Write Name

What type of foot problem are you having? ______________________

INSURANCE INFORMATION

(Please present your insurance card(s) to the receptionist)

Medical Insurance Company ______________________

☐ HMO ☐ PPO ☐ TRADITIONAL ☐ MEDICARE ☐ OTHER ______________________

Policy Holder / SSN / DOB ______________________

Secondary Insurance Company ______________________

Policy Holder / SSN / DOB ______________________

Responsible Party ______________________

Financial Agreement

Payment for office visits and laboratory work is due at the time of service unless prior arrangements have been made. To assist you, Arlington/Mansfield Foot & Ankle Centers, P.A. will accept insurance assignment for your surgical care. You are responsible for your deductible and co-insurance amounts.

Payment Preference ☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover ☐ CareCredit

Assignment of Benefits

I authorize payment of medical benefits to Arlington/Mansfield Foot & Ankle Centers, P.A. for services rendered.

Authorization for Treatment

I authorize Drs. Landry, Southerland, Warren, Rabjohn and/or Lawrence to treat my condition medically, surgically, and orthopedically.

Signed ______________________ Date ______________________

Arlington/Mansfield Foot & Ankle Centers

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Arlington/Mansfield Foot & Ankle Centers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Arlington/Mansfield Foot & Ankle Centers Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Arlington/Mansfield Foot & Ankle Centers reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Arlington/Mansfield Foot & Ankle Centers Privacy Office at 400 W. Arbrook Blvd. Suite 201, Arlington, Texas 76014.

With this consent, Arlington/Mansfield Foot & Ankle Centers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Arlington/Mansfield Foot & Ankle Centers may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Arlington/Mansfield Foot & Ankle Centers may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Arlington/Mansfield Foot & Ankle Centers restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Arlington/Mansfield Foot & Ankle Centers use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Arlington/Mansfield Foot & Ankle Centers may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

_______________________________ _______________________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

ARLINGTON/MANSFIELD FOOT & ANKLE CENTERS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND PHYSICIAN OWNERSHIP

I ______________________________ acknowledge that I have received a copy of Arlington/ Mansfield Foot & Ankle Centers, P.A. Notice of Privacy Practices. This Notice describes how Arlington/ Mansfield Foot & Ankle Centers, P.A. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

RELEASE OF PERSONAL HEALTH INFORMATION

I authorize AMFAC to disclose my protected health/billing information (PHI) to the following people listed below. This authorization allows AMFAC to disclose ALL medical/billing information to the people listed below unless stated otherwise. I understand that I can add or delete people at any time and must be done in writing, signed and dated.

Name **Relationship**

1.____

2.____

____

(Signature of Patient or Personal Representative) Date

____

(Relationship to patient)

ARLINGTON/MANSFIELD FOOT & ANKLE CENTERS

ACKNOWLEDGMENT OF AFFILIATIONS

In accordance with Texas law, this practice discloses that the physicians at Arlington/Mansfield Foot & Ankle Centers may have ownership interest in a surgical facility or medical supply company that is used in providing your care. However, please be assured that decisions and recommendations are made with the utmost concern for what is most appropriate and to ensure the best possible outcome for you as a patient.

Baylor Surgicare Mansfield
280 Regency Park
Mansfield, TX 76063

Pantheon Medical, LLC
1505 Federal St. Ste 300
Dallas, TX 75201

Synergy Aquatic & Land Therapies
Mansfield, TX 76063

____
(Signature of patient or responsible party) Date

____
(Relationship to patient)

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HEALTH QUESTIONNAIRE

Last Name: ______ First: ______
Height: ______ Weight: ______ Shoe Size: ______ D.O.B.: ______ Age: ______
Name of family Dr.: ______ M.D./D.O. Date of last visit: ______ City: ______
YOUR OCCUPATION: ______

DO YOU HAVE ANY ALLERGIES OR UNUSUAL REACTION TO THE FOLLOWING (nausea, rash, rapid heartbeat, etc.) ☐ **NONE**
(Check ALL that apply. List name of medication and reaction if known)

- ☐ Local anesthetics ______
- ☐ Penicillin ______
- ☐ Sulfa ______
- ☐ Other antibiotics (Name) ______
- ☐ Aspirin ______
- ☐ Anti-inflammatory ______
- ☐ Codeine ______
- ☐ Demerol ______
- ☐ Iodine ______
- ☐ Adhesive Tape ______
- ☐ Tetanus ______
- ☐ Latex ______
- ☐ Metals ______
- ☐ Other ______

MEDICATIONS: (Please list name including non-prescription medications) ☐ **NONE**

(1) ______ (6) ______ (11) ______
(2) ______ (7) ______ (12) ______
(3) ______ (8) ______ (13) ______
(4) ______ (9) ______ (14) ______
(5) ______ (10) ______ (15) ______

MEDICAL HISTORY: HAVE YOU EVER HAD (Check ALL that apply) ☐ NONE

- ☐ Diabetes ______
- ☐ High Blood Pressure ______
- ☐ Heart Disease / Heart Attack ______
- ☐ Bleeding Disorders ______
- ☐ Phlebitis / Blood Clots / DVT ______
- ☐ Any Kidney Disease ______
- ☐ Any Liver Disease / Hepatitis ______
- ☐ Asthma / COPD / Emphysema ______
- ☐ Stomach / Ulcer / Colitis / GERD ______
- ☐ Neuropathy ______
- ☐ Depression / Nervous Disorder ______
- ☐ Epilepsy / Seizures / Stroke ______
- ☐ Arthritis / Gout ______
- ☐ Tumors or Cancer (TYPE) ______
- ☐ HIV Exposure (AIDS) ______
- ☐ Injury to Feet, Ankles, Legs or Back ______
- ☐ High Cholesterol ______
- ☐ Hypothyroidism ______
- ☐ Other ______

SURGICAL HISTORY: (List all and approximate year and any complications) ☐ **NONE**

(1) ______ (4) ______
(2) ______ (5) ______
(3) ______ (6) ______

FAMILY AND SOCIAL HISTORY:

Are you pregnant? ______ Yes No
Is there a family history of diabetes? ______ Yes No
Is there a family history of hypertension? ______ Yes No
Is there a family history of heart disease? ______ Yes No
When was your last tetanus immunization? ______
Do you smoke? Yes No Quit ______ packs a day
Do you use any other tobacco product? Yes No What? ______
Do you use alcohol? Yes No ______ occ. socially freq.
Do you take any addicting drugs? ______ Yes No
Have you been hospitalized in the last 2 years? Yes No
Why? ______

PHYSICIAN ONLY

Signature: ______ Date: ______
(Patient or Legal Guardian)

IF YOU HAVE ANY QUESTIONS ABOUT THE INFORMATION WE ARE REQUESTING, PLEASE ASK. THIS INFORMATION WILL ASSIST THE DOCTOR IN PROVIDING YOU WITH THE SAFEST AND MOST EFFECTIVE CARE POSSIBLE.