ARLINGTON / MANSFIELD
Foot & Ankle Centers
Part of Stride Healthcare

JOHN R. LANDRY, D.P.M.
JOE T. SOUTHERLAND, D.P.M.
RYAN N. LAWRENCE, D.P.M.

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HEALTH QUESTIONNAIRE

PLEASE PRINT CLEARLY

Last Name:_____ First: _____
Height:_____ Weight: _____ Gender: _____ 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)

- ☐ 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 (CIRCLE) _____
- ☐ Bleeding Disorders _____
- ☐ Phlebitis / Blood Clots / DVT (CIRCLE) _____
- ☐ Any Kidney Disease _____
- ☐ Any Liver Disease / Hepatitis (CIRCLE) _____
- ☐ Asthma / COPD / Emphysema (CIRCLE) _____
- ☐ Stomach / Ulcer / Colitis / GERD (CIRCLE) _____
- ☐ Neuropathy (TYPE) _____
- ☐ Depression / Anxiety (CIRCLE) _____
- ☐ Epilepsy / Seizures / Stroke (CIRCLE) _____
- ☐ Arthritis (TYPE) _____
- ☐ Gout _____
- ☐ Tumors or Cancer (TYPE) _____
- ☐ HIV Exposure _____
- ☐ Injury to Feet, Ankles, Legs or Back _____
- ☐ 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 vape?_____ Yes No
Have you been hospitalized in the last 2 years? Yes No
Date: _____ Reason: _____

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.

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PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date _____

Patient Name _____ Date of Birth _____ Gender: _____

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 _____

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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)

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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

Synergy Aquatic & Land Therapies
Mansfield, TX 76063

(Signature of patient or responsible party) Date

(Relationship to patient)

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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

Stride Healthcare

Name_____ Date_____

Do I Need a Test for Peripheral Arterial Disease?

***Peripheral Arterial Disease is a serious circulatory condition in which the blood vessels of your arms & legs become narrowed or clogged, resulting in reduced blood flow.**

***People with peripheral arterial disease are at a significantly increased risk for amputations, stroke and heart attack, Most of these conditions can be prevented with early detection and proactive care**

Answer the question below to help up determine if you are at risk for peripheral arterial disease and if an in-office vascular exam will help better assess your circulatory status. Please check all that apply below:

Are you experiencing any of the following symptoms to your lower legs, feet or toes?

- □ Skin Changes: Pale, Dry, Discolored blue
- □ Cold feeling/Cool to touch
- □ Hair Loss on Feet or Legs
- □ Pain While Walking Legs/feet
- □ Pain at rest legs/feet or while sleeping
- □ Fatigue in Legs after short periods of walking
- □ Cramping in legs/feet
- □ Ulcers, sores or wounds with slow healing

Do you or have you had any of the following:

- □ Smoking or History of tobacco use
- □ Diabetes
- □ Coronary Artery Disease
- □ Chronic Kidney Disease
- □ High Blood Pressure/High Cholesterol
- □ History of Heart Attack/Congestive Heart Failure
- □ History of Stroke
- □ Previous Leg Surgery/Arterial Surgery

*Your doctor will review this form so he/she can determine if you need to be screened for PAD.

Signature _____ Phone Number_____ Date_____

Stride Healthcare

Name_____ Date_____

Do I Need a Test for Chronic Venous Insufficiency?

***Chronic venous insufficiency (CVI) is a serious circulatory problem that occurs when the venous wall and/or valves in the leg veins are not working effectively, making it difficult for blood to return to the heart from the legs. It affects millions of Americans, most over the age of 40. Symptoms of CVI include varicose veins, skin problems, leg and ankle swelling, tight calves, and legs that feel heavy, tired, restless, or achy. Factors that can increase the risk of CVI include pregnancy, obesity, smoking, standing or sitting for long periods of time, and not getting enough exercise.**

Answer the question below to help up determine if you are at risk for CVI and if an in-office vascular exam will help better assess your vascular health status.

Please check all that apply below:

- ☐ Do you have varicose veins and heavy, tired, restless, or achy legs?
- ☐ Do you have varicose veins with inflammation (redness, swelling, pain, and heat) in your leg(s)?
- ☐ Do you have varicose veins and an ulcer and inflammation in your legs(s)?
- ☐ Do you have a non-healing ulcer around your ankle or sock line with shiny or leathery looking skin?
- ☐ Have you had a Deep Vein Thrombosis (DVT) in the past and are experiencing pain, swelling, changes in skin color, or cellulitis?

Other Comments or Notes: _____

_____

_____

*Your doctor will review this form so he/she can determine if you need to be screened for PAD.

Signature _____ Phone Number_____ Date_____