FORT WORTH PODIATRY

*Put Your Best Foot Forward*

## PATIENT DEMOGRAPHIC

**First Name** _____ **M.I.** _____ **Last Name** _____ **DOB** _____

**Street Address**_____ **City** _____ **State** ____**Zip code** _____

**Home Phone (____)** _____ **Work Phone (____)** _____ **Cell Phone (____)** _____

**E-Mail Address** _____ **Preferred Name:** _____

**Gender** □ F □ M **Marital Status** □ Married □ Divorced □ Separated □ Single □ Widowed **1st Lang.** □ Engl. □ Other

**Race: (Choose all that apply)** **Ethnicity:**

□ White □ Native Hawaiian or other Pacific Islander □ Asian | □ Hispanic

□ Black or African American □American Indian or Alaska Native □ Other | □ Not Hispanic

Driver's License: _____ State: _____ Social Security no. _____

**Pharmacy of Choice** _____ **Pharm. Phone** _____

**Pharmacy Full Address** _____

**Primary Care Physician** _____

**Employed □ PT □ FT □ Retired □ None Employer** _____

**How did you hear about our practice?** _____

□ Internet (Source_____) □ Friend/Family Member/Patient Name: _____

**Emergency Contact** _____ **Relationship to Patient** _____

**Cell Phone Number (____)** _____ **Alternate Phone Number (____)** _____

## INSURANCE INFORMATION

### PRIMARY

**Insurance Company:** _____ **Insurance ID Number:** _____

**Group Number:** _____ **Primary Subscriber Name:** _____

**Primary Subscriber Birth Date:** _____ **Relationship to Patient**_____

### SECONDARY

**Insurance Company:** _____ **Insurance ID Number:** _____

**Group Number:** _____ **Secondary Subscriber Name:** _____

**Secondary Subscriber Birth Date:** _____ **Relationship to Patient:** _____

**Financially Responsible Person if not Patient: First Name** _____ **Last Name** _____

**Gender □ F □ M Birth Date**_____/_____/_____ **Street Address** _____

**City** _____ **State** _____ **Zip code** _____

**Home Phone (_____)** _____ **Work Phone (_____)** _____ **Cell Phone (____)** _____

**Signature of Responsible Party** _____ **Date**_____

**Relationship (if not Patient)** _____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Fort Worth Podiatry and all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Fort Worth Podiatry may use my health care information and may disclose such information to the disclosed 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.

**X**_____ _____

**PATIENT/GUARDIAN SIGNATURE** **DATE**

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## NOTICE TO PATIENTS REGARDING INSURANCE

While we make every effort to assist you with your insurance questions and submissions, it is YOUR responsibility to verify your insurance coverage and to understand the extent of that coverage. Insurance companies are obligated to YOU, the insured, and not to our office. It is often difficult or impossible for us to get information regarding your insurance. Together, we can make sure you receive the best care possible under your insurance company guidelines.

## PATIENT FINANCIAL POLICY

- _____ (Initial) I understand that it is my responsibility to know and understand my insurance coverage.
- _____ (Initial) I understand that specialist co-pays (which may be different than my Primary Care Benefits), deductibles and coinsurance are due prior to services being rendered. I understand that this is a contractual agreement with my health plan to collect co-pays and deductibles at the time of service. I understand that once the claims have been adjudicated by my insurance company, there is a possibility that I may end up receiving a balance statement or a credit.
- _____ (Initial) I understand that all health plans are not the same and do not cover the same services. In the event that my health plan determines that a service is "not covered" or that I do not have authorization, I am responsible for charges for any services rendered. ***Patients are encouraged to contact their plans for clarification of benefits prior to services rendered***
- _____ (Initial) I understand that **Nail trimming, Callus shaving and Corn removal** are **not covered by my insurance** for non diabetic patients, and therefore this charge will not be billed to my insurance company and is a self-pay service of **$50.00.**
- _____ (Initial) I understand that my insurance company may request information from me before processing a claim. It is my responsibility to comply with their request. Failure to comply may result in denial of my claim. I will be responsible for all charges incurred.
- _____ (Initial) I understand that I am responsible for **all authorization/referrals** needed to seek treatment in this office.
- _____ (Initial) I understand that it is my responsibility to inform **Fort Worth Podiatry** of ANY insurance changes and **authorization/referral requirements** at the time of appointment. In the event that FWP is not informed, I will be responsible for any charges denied.
- _____ (Initial) There are **NO refunds** for supplies purchased in the office, such as **Orthotics and all over the counter products**. Unfortunately, not every supply prescribed works for all patients, but we strive to ensure we make every effort to have a satisfactory outcome
- _____ (Initial) I understand that I will be billed for any amounts due by me (co-payments / co-insurance amounts / deductibles)and that I have a financial responsibility to pay these amounts. I understand that I will be provided with **two (2) statements** for any balance due after insurance payment. I further that understand that if I have not made within 30 days of the second statement being mailed, that my account will be sent to collections
- _____ (Initial) Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be my responsibility in addition to the balance due to Fort Worth Podiatry.
- _____ (Initial) I understand that if I present an insufficient funds check (NSF check) for payment on my account, I will be charged a **$35 NSF fee**. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- _____ (Initial) I understand that there is a **$25 fee** to complete disability paperwork **(FMLA)**. If additional disability forms require completion, I understand that an additional $25 fee (payable prior to compilation) is required.
- _____ (Initial) I understand that I need to **cancel my appointment 24 hours prio**r to my scheduled appointment time or I will be charged a **fee of $ 25.00** for a same day cancel or no show fee.
- _____ (Initial) I understand that I need to **cancel my scheduled surgery 72 hours prior** to my scheduled surgery date to avoid a **$50.00 surgery cancellation fee.**

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## SUMMARY NOTICE OF PRIVACY PRACTICES AND HIPAA

Patient Name: _____ Date of Birth: _____ Today's Date: _____

The Notice of Privacy Practices (**NPP**)contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (**HIPAA**).

**Uses and Disclosures of Health Information.** We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students

**Uses and Disclosures Based on Your Authorization.** Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

**Uses and Disclosures Not Requiring Your Authorization.** In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law;
- To a collection agency and may provide protected health information to that agency in the event you do not satisfy your financial responsibilities.

**Patient Rights.** As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

**If you have a question, concern or complaint regarding our privacy practices, please contact our office at (817) 731-4279**

I, _____ (Print Name of Patient or Legal Representative--Patient DOB _____), acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read and understood the Notice. This authorization may be revoked by me at any time in writing. In addition, I authorize the following people access to my personal health information upon request (including leaving a detailed message):
□ Spouse □ Other: Name/Relationship: _____
Leave a detailed message on these voicemails/cell:

_____ _____
Signature of Patient or Legal Representative Date

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## COMPREHENSIVE HEALTH REVIEW

**Patient Name:** _____ **Date of Birth:** _____ **Today's Date:** _____

### HISTORY OF PRESENT ILLNESS

What is your specific foot/ankle problem? _____

When did the problem begin? _____

The problem is: □Improving □Worsening □Unchanged

What aggravates the problem?_____

What improves the problem? _____

Is the problem painful? □Yes □No

Which foot/ankle is involved? □Right □Left □Both

First visit to a doctor for this problem? □ Yes □No

Have you had a similar problem in the past? □ Yes □No

How was the problem onset? □ Sudden □ Gradual

The problem is worst: □AM □PM □At Rest □With Activity

If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain:

□Sharp □Burning □ Clicking □Aching □Throbbing □Tingling

□Dull □Shooting □Cramping □Itching □Popping □Stabbing □Other:_____

Describe previous treatments: _____

Is this from an injury? □Yes □No If so, is it work-related? □Yes □No Describe: _____

### PAST MEDICAL HISTORY

***Are you diabetic?*** ***□Yes □ No If yes, name of physician managing diabetes*** _____ ***Date last seen*** _____

□Diabetes: Type □1 □2
Duration: ____ years
Last Blood Sugar _____ HbA1c ___

□Acid Reflux
□Anemia
□Anesthesia Complications
□Arthritis ( Osteo / Rheum)
□Asthma
□Back Problems/Sciatica
□Blood Clot/DVT
□Cancer: _____
□Cellulitis/Skin Infection
□Circulation Problem
□Dementia/Alzheimer's
□Excessive/Easy Bleeding
□Fibromyalgia
□Foot/Leg Ulcer
□Gout
□Healing Problems/Keloids
□Heart Disease/Heart Attack
□High Blood Pressure ( Low BP?)
□High Cholesterol
□Hormone Therapy
□Immune Disorder/HIV
□Kidney Disease ( Dialysis)
□Liver Disease ( Hepatitis)
□Leg Cramps/Leg Pain at Rest
□Lung Condition:
□Mitral Valve Prolapse/Murmur
□MRSA
□Multiple Sclerosis
□Nervous Disorder/Depression
□Neuropathy
□Osteomyelitis/Bone Infection
□Parkinson's Disease
□Previous Addiction to:
_____
□Pulmonary Embolism
□Rashes/Skin Condition
□Raynauds Disease/Phenomena
□Seizure Disorder/Epilepsy
□Sickle Cell Disease/Trait
□Sleep Apnea
□Stomach Ulcers
□Stroke □Rt □Lt (year _____)
□Thyroid Condition ( □Hi □Lo)
□Varicose Veins

**□Women – Are You?**
□Pregnant or □Breast Feeding?
□ Other problems not listed:

### PAST SURGERIES

□Foot/Ankle Surgery: _____
□Joint Replacement: _____
□Open Heart/Bypass Surgery
□Hysterectomy: □Tubal ligation □C-Section
□Stent Placement: □Heart □Leg
□Cosmetic Surgery:_____
□Appendix □Gallbladder □Tonsils/Adenoids
□Leg Bypass □Open Fracture Repair
□Carotid Surgery □Vein Surgery
□Hernia repair □Thyroid □Back surgery
□Other: _____

### FAMILY HISTORY

| | Mother•Father•Sister•Brother•GrandParent |
|---|---|
| Cancer | □M □F □S □B □GP |
| Diabetes | □M □F □S □B □GP |
| Gout | □M □F □S □B □GP |
| Heart Disease | □M □F □S □B □GP |
| High Blood Pressure | □M □F □S □B □GP |
| Chronic Arthritis | □M □F □S □B □GP |
| Anesthesia Complications | □M □F □S □B □GP |
| Foot Problems | □M □F □S □B □GP |
| Other: _____ | □M □F □S □B □GP |
| Other: | □M □F □S □B □GP |

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## COMPREHENSIVE HEALTH REVIEW

**Patient Name:** _____ **Date of Birth:** _____ **Today's Date:** _____

**MEDICATIONS (include RX meds, OTC meds, and vitamins)** - *Use The Back of Sheet If Necessary*

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**ALLERGIES**

□None □Adhesives/Tape □Aspirin □Codeine □Cortisone □Sulfa Drugs

□Iodine □Latex □ Local Anesthetics □Penicillin □Seafood/Shellfish

**SOCIAL HISTORY**

Occupation: _____ I Stand _____ % of My Day

□I Drink Alcoholic Beverages How much/often? _____ I Exercise Each Week: □ 0 days □ 1-2 days □ 3+ days

□I Use or Have Used Tobacco Products Type: _____ List Sports/Activities: _____

Packs/Day _____ Years _____ When Stopped? _____ _____

□ I Use or Have Used Drugs that are Illegal_____ □ My foot/ankle problem limits my activities

I Live With: □No One □Spouse □Children □Parents □Other

**REVIEW OF SYSTEMS**

**CONSTITUTIONAL**
□Recent Weight Changes Fever/Chills
□Nausea or Vomiting
□Fatigue

**EYES**
□Eye Disease/Injury
□Wear Glasses/Contacts
□Blurred or Double vision
□Glaucoma

**EARS/NOSE/MOUTH/THROAT**
□Hearing Loss
□Nose Bleeds
□Sore Throat/Voice Change
□Sinus Problems
□Difficulty Swallowing

**INTEGUMENTARY**
□Rash or Itching
□Dry Skin
□Change in Hair/Nails

**GASTROINTESTINAL**
□Indigestion/Heartburn
□Diarrhea
□Blood in Stools
□Stomach Pains

**CARDIOVASCULAR**
□Chest Pain
□Palpitations
□Arrhythmia/Irregular Heartbeat
□Leg Pain when Walking
□Swelling of Hands/Feet

**RESPIRATORY**
□Shortness of Breath
□Chronic/Frequent Cough
□Wheezing

**GENITOURINARY**
□Frequent Urination
□Painful Urination
□Kidney Stones
□Blood in Urine

**ENDOCRINE**
□Hormonal Problem
□Excessive Thirst
□Excessive Urination
□Too Hot/Too Cold

**NEUROLOGICA**
□Migraines
□Frequent Headaches
□Numbness/Tingling
□Dizzy Spells
□Paralysis/Tremors

**PSYCHIATRIC**
□Anxiety
□Depression
□Nervousness
□Insomnia
□Confusion/Memory Loss

**MUSCULOSKELETAL**
□Muscle Pain or Cramps
□Joint Pain
□Stiffness/Swelling Joints
□Low Back Pain
□Trouble Walking

GASTROINTESTINAL

STATISTICS

Age _____ Height _____ Weight _____ Shoe Size _____

**Fort Worth Podiatry • 3221 Hulen St, Suite A • Fort Worth,TX 76107**

**Phone: (817) 731-4279 • Fax: (817) 731-0693 • Website: fwpodiatry.com**