PATIENT NAME: _____ **DOB:** _____

FOR EVERY VISIT THESE QUESTIONS ARE REQUIRED BY MEDICARE.

HAVE YOU....

- BEEN HOSPITALIZED WITHIN THE LAST 30 DAYS? YES OR NO
- FALLEN WITHIN THE LAST 12 MONTHS? YES OR NO
- RECEIVED A FLU SHOT THIS YEAR? YES OR NO
- USED TOBACCO? YES OR NO
- RECEIVED THE PNEUMONIA VACCINE THIS YEAR? YES OR NO
- HAVE ANY OF YOUR MEDICATIONS CHANGED? YES OR NO

IF SO, LIST BELOW:

_____ _____

_____ _____

PRIMARY CARE PHYSICIAN ****Must be a doctor of Family Medicine, Primary Care, Internal Medicine, Endocrinology**

NAME: _____ DATE LAST SEEN: _____

(PLEASE NOTE: Medicare related insurances require Primary Care Physician be listed for certain services to be paid)

ON A SCALE OF 0-10, WHAT IS YOUR CURRENT PAIN LEVEL? _____

THE FOLLOWING QUESTIONS ARE FOR PATIENTS 65 YEARS OF AGE OR OLDER:

DO YOU HAVE A LIVING WILL? YES OR NO

DO YOU HAVE SOMEONE WHO MAKES DECISIONS ON YOUR BEHALF? YES OR NO

THE FOLLOWING QUESTIONS ARE FOR DIABETIC PATIENTS ONLY: TYPE 1 OR TYPE 2

- WHAT DATE WAS YOUR LAST A1C TEST PERFORMED? _____
- WHAT WAS YOUR A1C TEST RESULT? _____
- NAME OF PHYSICIAN WHO PERFORMED THE TEST? _____

Revised 9/15/21

SIGNATURE:_____ TODAYS DATE: _____

FOOT & ANKLE CENTER OF DALLAS

Patient Name: _____ **Date of Birth:** _____ **Sex:** ___M___F

Address: _____
Street Apt. No City State Zip

Home#: _____ **Work#:** _____ **Cell #:** _____

Email: _____ **** Circle preferred method for reminder calls.**

Emergency Contact: _____ **Emergency Phone:** _____

Primary Language: _____ Employed:___Y___N Occupation:_____

Ethnicity: _____ Marital Status (circle): Married Single Divorced Widowed Partner

PRIMARY CARE PHYSICIAN ****Must be a doctor of Family Medicine, Primary Care, Internal Medicine, Endocrinology**

Name: _____

Primary Physician Phone: _____ Date Last Seen: _____

PLEASE NOTE: Medicare related insurances require that a Primary Care Physician be listed for certain services to be paid

HOW DID YOU HEAR ABOUT US? (circle)

Physician Internet Insurance Friend Family Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ Employer: _____

Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Patient Relationship to Policy Holder: _____

SECONDARY INSURANCE NAME: _____ Employer: _____

Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Patient Relationship to Policy Holder: _____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Foot & Ankle Center of Dallas to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Foot & Ankle Center of Dallas on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Foot & Ankle Center of Dallas for charges for the above patient regardless of my insurance coverage. I also understand that Foot & Ankle Center of Dallas is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Foot & Ankle Center of Dallas permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained during the course of my treatment.

Patient's Signature: _____ Date: _____

FOOT & ANKLE CENTER OF DALLAS

Patients Name: _____ **Shoe Size:** _____

Reason for your visit: _____ **Pain Level:** _____

Alcohol Intake: _____ **Caffeine Intake:** _____
Smoker: _____ pack(s)/day X _____ years **Previous smoker:** YES NO How much/long: _____
Height: _____ **Weight:** _____

Constitutional: Are you currently experiencing (please circle): Nausea Vomiting Fever Chills Night Sweats

Date of Last Flu Vaccine: _____ **Pneumonia Vaccine:** _____ **COVID Vaccine:** _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

Pharmacy Location and/or Address: _____

Medications: List current medications & dosage: _____

_____ _____

_____ _____

Past Medical History: If you have or have had any of the following conditions, please Check ALL that apply.

- ☐ Athlete's Foot
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Currently Pregnant
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Dialysis
- ☐ Eczema
- ☐ Endocrine Disorder
- ☐ Epilepsy
- ☐ Fibroid Tumors
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Heart Attack
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Immune Disease
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Lymphedema
- ☐ Nail Disease
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease (PAD)
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ OTHER:

Allergies: Yes No If yes, please list: _____

_____

Family History: Please circle any medical conditions that run in your family and write which member(s) affected.

Diabetes _____ Gout _____ Heart Disease_____ Circulation Problems_____ High Blood Pressure_____

High Cholesterol_____ Other_____

Surgeries: List all surgeries you have had. Begin with the most recent. Please give the year.

_____

_____

If **diabetic**, who handles your diabetes? _____ Phone #: _____

Last A1C? _____ Date Performed: _____ Performed by: _____

FOOT & ANKLE CENTER OF DALLAS

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your Pre-op appointment.
- 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 your responsibility in addition to the balance due to the office.
- Patients who are 90 days past due on their balance will be sent to collections unless a payment plan has been put into place.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- In fairness to all our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor.
- Patients who come to office fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient/ Responsible Party: _____ Date: _____

Printed Name of Patient/ Responsible Party: _____ Date: _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The terms of this notice may change. If so, you will be notified at your next visit to update your signature and date.

By signing this form, you consent to our use and disclosure of your protected healthcare information according to the indications below.

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- This privacy policy may be changed by the practice, when necessary, as required or allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- This privacy policy will stay in effect until the time that it is revoked by the patient or changed as required by law.

PLEASE INDICATE YOUR PREFERENCES REGARDING YOUR PERSONAL HEALTHCARE INFORMATION:

Health notifications:	____ E-mail	____ Phone	____ Text message
Auto Appointment Reminders:	____ E-mail	____ Phone	____ Text message
Practice Announcements:	____ E-mail	____ Phone	____ Text message
Billing information:	____ E-mail	____ Phone	____ Text message

Please indicate the phone number and/or e-mail you would like to use below:

_____

May we discuss your medical condition with a family member? ____ Yes ____ No
If YES, please list the name of the members allowed:

_____ Relationship to patient _____

_____ Relationship to patient _____

I consent to have my medical records shared with other Premier Foot & Ankle/ Stride Healthcare providers.
____ Yes ____ No - Only upon my request

I consent to have my medical records shared with my care providers outside the Stride Healthcare network.
____ Yes ____ No - Only upon my request

This consent was signed by: _____
(PRINTED NAME PLEASE)

Patient or Guardian Signature: _____ DATE: _____