FOOT AND ANKLE CENTER OF FRISCO/PLANO

Please Print **Date:**_____

Patient Information

Name:_____ Date of Birth:___ / ___ / ____ Age: _____

Home Address:_____City:_____State:_____Zip:_____

Sex: ☐ M ☐ F_____ Marital Status: ☐ M ☐ S ☐ W ☐ D Driver's License #:_____

Social Security #:_____ Parent or Guardian_____

Pharmacy Name:_____ Pharmacy Phone:_____

Contact Information

Home:_____ Work:_____

Cell:_____ Email:_____

Employed by:_____Occupation:_____

Address:_____City:_____State:_____Zip:_____

Insurance Information

Medical Insurance:_____Group/Policy:_____ID#_____

Other Insurance:_____Group/Policy:_____ID#_____

Name of Policy Holder_____ Date of Birth_____SS#_____

Is this a work related injury? ☐ Yes ☐ No If Yes, Date of Accident:_____

Place of Accident:_____Claim #:_____Adjustor:_____

Emergency Contact

Relative/Friend not living with you:_____Phone:_____

Name of Guarantor (If other than patient):_____DOB:_____Age:_____

Employed by:_____Work Phone:_____ SSN:_____

Referral Policy

If your insurance is a part of Managed Care plan (HMO, POS, EPO, etc.), failure to obtain a valid referral from your primary care physician (PCP) may result in reduced or no benefits being payable.

Non-Covered Foot Care

Your insurance carrier may determine that your foot care is an excluded service, in which case no reimbursement will be made. Should this occur, the responsibility of payment will remain yours as the recipient of these services. (This includes orthotics, splints, over the counter medications, heel cups, pads, toe separators, i.e., anything that is given to you in this office that your carrier may not pay).

Please Sign Below

I authorize use of this form on all my insurance submissions and release of information to all my insurance companies. I acknowledge responsibility for payment of any deductibles, co-insurance, and unauthorized or non-covered services. I accept responsibility for any unpaid bills sixty days after insurance is filed. If for any reason the account becomes delinquent, I agree to pay for all collection and legal lees. I authorize the doctor & Foot and Ankle Center of Frisco/Plano to act as my agents in helping me obtain payment from my insurance company. I request payment of my insurance benefits be made directly to Foot and Ankle Center of Frisco/Plano for any services furnished to me by my physician. I permit a copy of this authorization to be used in piece of the original. I hereby give permission to physicians of Foot and Ankle Center of Frisco/Plano to examine and administer treatment after consultation and perform such procedures, as may be deemed necessary, in the diagnosis and/or treatment of my condition.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Foot and Ankle Center of Frisco/Plano and that I have read (or had the opportunity to read if I chose so) and understood the Notice.

Signature of Patient or Legal Representative:_____ **Date:**_____

FOOT AND ANKLE CENTER OF FRISCO/PLANO

Name: _____ **Date:** _____

Have you had/been treated for:

__Corns/Calluses
__Leg or Foot Ulcers
__Broken foot bone(s)
__Hammer/Mallet toes
__Cramps in legs/feet
__Lower back pain
__Gait (walking) problems
__Childhood foot problems
__Warts
__Fungal Nails
__Neuroma
__Broken Ankle
__Bunions
__Arch pain
__Knee pain
__In-Toeing
__Rash
__Athlete's Foot
__Ingrown nails
__Foot numbness
__Ankle sprain
__Flat feet
__High arch feet
__Heel pain
__Toe walking
__***NONE of these***

Did you previously or do you now wear: (CIRCLE)

Shoe inserts? **Y N** Still using them? **Y N** Do or did they help? **Y N**
Orthotics? **Y N** Still using them? **Y N** Do or did they help? **Y N**

The orthotics were obtained from: __ Another Podiatrist __An Orthopedist
__A Physical Therapist __A Chiropractor __Other:_____

Are your first steps out of bed painful? **Y N** …then subsides? **Y N**
Do you get leg cramps …during the day? **Y N** …at night? **Y N**

Percent of the waking hours spent on your feet? **20% 40% 60% 80% 100%**

List the sports/type of dance you are active in:

_____

Does foot pain limit your desired activities? __Yes __No
Do you have any difficulty in walking? __Yes __No
Any pain in calves or buttocks when walking? __Yes __No
Is the pain relieved by stopping and standing still? __Yes __No

Do you have or have you ever been treated for:

__Stroke
__Phlebitis
__Anemia
__Diabetes
__Gout
__Sciatica
__Arthritis
__Epilepsy
__Asthma
__Hepatitis
__Dark Urine
__Cancer
__Heart attack
__Vascular Disease
__Poor Circulation
__Kidney Disease
__Osteoporosis
__Lyme's Disease
__Headaches
__Nerve Disorder
__Lung Disease
__Liver Disease
__Chronic Lt. Stool
__Stomach Ulcer
__High Blood Pressure
__A Heart Condition
__Eyes: Glaucoma/MacularDeg.
__Keloid/ Thick Scar
__Alzheimer's
__Rheumatic Fever
__Hearing/Ear Disorder
__Psychiatric Disorder
__Tuberculosis
__Thyroid Problem
__Unexplained Weight Loss
__***NONE of these***

__Other(s): _____

Do you have vascular grafts? *(If yes, explain below)* __Yes __No
Do you have joint implants? *(If yes, explain below)* __Yes __No
Do you have replacement heart valves? __Yes __No
Are you now under active chemotherapy? __Yes __No
Have you had any other serious illness? *(List below)* __Yes __No
Have you had any surgery? *(If yes, explain below)* __Yes __No
Have you ever been hospitalized or been under medical care over 24 hours? *(If yes, explain below)* __Yes __No

I had Surgery for:	on date of:	w/ complications of:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List relationship to you of family members who have had:

Diabetes _____ Foot problems _____
Arthritis_____ Heart Attack_____
Stroke_____ High Blood Pressure_____
Cancer_____ Birth Defects_____

# of childbirths ____ Are you currently pregnant? ___Yes ___No

Are you slow to heal after cuts? ___**Yes** ___**No**
Any abnormal bruising, bleeding or scarring? ___**Yes** ___**No**

Do you smoke now? __**Yes** __**No** **Packs/day**____ **Years**_____
Did you ever smoke? __**Yes** __**No** **Packs/day**____ **Years**_____
If you quit. When did you do so? _____

Alcoholic beverages? *(Circle one)* **None** Rarely Moderately Daily Quit

Recreational drugs? *(Circle one)* **None** Rarely Moderately Daily Quit

Please mark if you take vitamins or supplements that contain:
__Garlic __Gingko Biloba __Echinacea __Ginseng __St. John's Wort

Are you currently taking any medications? *(List below)* ___Yes ___No
Are you taking insulin? *(If yes, list below)* ___Yes ___No

When noting frequency: **A**=As Needed **x/**=Times Per **D**=Day **W**=Week

List:	Medications:	Dose?	How Often?	For Treatment of?

_____ _____A,_____ x/DW,_____
_____ _____A,_____ x/DW,_____
_____ _____A,_____ x/DW,_____
_____ _____A,_____ x/DW,_____
_____ _____A,_____ x/DW,_____
_____ _____A,_____ x/DW,_____

Are you taking your medications as prescribed? ____Yes ____No

Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral or topical administration of:

(Check the answer box that applies)	*No*	*Yes*	*If yes, what happens?*
Penicillin……	☐	☐	_____
Other antibiotics *(list below)*……	☐	☐	_____
Empirin, Tylenol (if yes, circle)……	☐	☐	_____
Aspirin, Advil, Aleve, or Motrin (circle)……	☐	☐	_____
Celibrex, Bextra, Vioxx (circle)……	☐	☐	_____
Other pain remedies (list below)……	☐	☐	_____
Morphine……	☐	☐	_____
Codeine……	☐	☐	_____
Demerol……	☐	☐	_____
Other narcotics (list below)……	☐	☐	_____
Novocaine……	☐	☐	_____
Other anesthetics (list below)……	☐	☐	_____
Sulfa drugs……	☐	☐	_____
Adhesive tape……	☐	☐	_____
Shrimp, Iodine, or Merthiolate……	☐	☐	_____
Any other drugs or medications……	☐	☐	_____

Others:_____

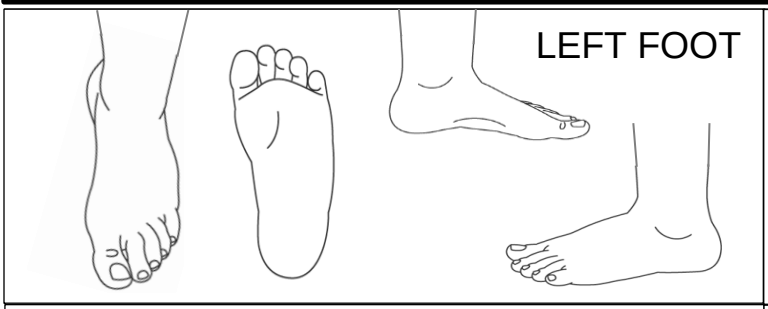
Anything else that you want to tell the doctor? ___**Yes** ___**No**

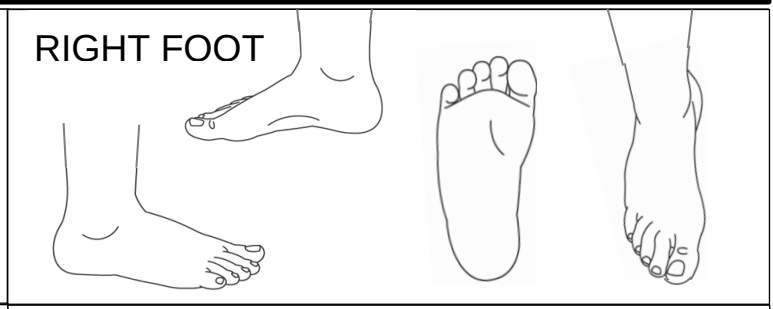
Illnesses / Explanations:_____
_____
_____
_____

FOOT AND ANKLE CENTER OF FRISCO/PLANO

Name: _____ **Date:** _____

Describe **1** or **2** main problems in greater detail below & mark the diagrams below the area where you have each problem using numbers **1** & **2** to identify.





1. Please mark the location of your first problem or pain on the diagrams above with the number 1. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My first problem is __On Left foot __On Right foot __Both Feet
It causes me difficulty ___walking __wearing shoes, and/or it…

_____
_____
_____
_____
_____

_____ **Is problem work related? Y N**

Date of injury: ___/____/____ Date of report to employer: ___/___/____

Pain: Please indicate the severity of your pain or discomfort:
0: None 1: Light 2: Moderate 3: Strong 4: Severe

My Pain/Discomfort is:
_____ Shooting Pain
_____ Throbbing Pain
_____ Sharp Pain
_____ Burning Pain
_____ Itching
_____ Aching Pain
_____ Tenderness
_____ Dull Pain
_____ Tingling
Numbness

How long ago did the problem (pain) start?:
____ ☐ Days ☐ Weeks ☐ Months ☐ Years Ago

The pain from my problem occurs:
☐ while walking and/or ☐ while not walking
☐ and/or _____

Previous medical treatment(s) or home remedies

_____
_____
_____
_____

2. Please mark the location of your second problem or pain on the diagrams above with the number 2. Describe your problem below and its cause if you know. Please describe associated pain to the right ➡

My first problem is __On Left foot __On Right foot __Both Feet
It causes me difficulty ___walking __wearing shoes, and/or it…

_____
_____
_____
_____
_____

_____ **Is problem work related? Y N**

Date of injury: ____/____/____ Date of report to employer: ___/___/____

Pain: Please indicate the severity of your pain or discomfort:
0: None 1: Light 2: Moderate 3: Strong 4: Severe

My Pain/Discomfort is:
_____ Shooting Pain
_____ Throbbing Pain
_____ Sharp Pain
_____ Burning Pain
_____ Itching
_____ Aching Pain
_____ Tenderness
_____ Dull Pain
_____ Tingling
_____ Numbness

How long ago did the problem (pain) start?:
____ ☐ Days ☐ Weeks ☐ Months ☐ Years Ago

The pain from my problem occurs:
☐ while walking and/or ☐ while not walking
☐ and/or _____

Previous medical treatment(s) or home remedies

_____
_____
_____
_____

Patient's Doctors – Please Tell Us Whom To Thank And With Whom To Coordinate Your Care

My:	Physician's Name:	Phone Number:	City:	Date Last Seen:	Referred me:		I was sent or came in especially for:
Family Primary	_____	_____	_____	___ / ___ / ___	Y	N	2nd Opinion Surgical Eval Consult
Specialist	_____	_____	_____	___ / ___ / ___	Y	N	2nd Opinion Surgical Eval Consult
Other Podiatrist	_____	_____	_____	___ / ___ / ___	Y	N	2nd Opinion Surgical Eval Consult

For Doctor's Use – Observations & Comments

☐ **Patient was** ○ assisted in completion of this record by or was ○ unable to complete with the help of:
☐ **Translation was done by** _____ **in** ○ **Spanish** ○ _____
☐ **Additional information⁺ obtained from** ○ Family/Care givers and/or ○ Physician(s) _____
☐ **Lab Reports⁺** and/or ☐ **Previous Medical Records⁺ were reviewed.** ☐ **X-rays⁺ brought by patient from** _____
⁺**Elaborations:** _____
Doctor's Signature X_____ **Date:** _____

FOOT AND ANKLE CENTER OF FRISCO/PLANO

Please Print **Date:**_____

REQUEST FOR CONFIDENTIAL COMMUNICATION

NAME OF PATIENT (PLEASE PRINT) _____ **DATE OF BIRTH** _____

KEEPING OUR PATIENT'S INFORMATION PRIVATE IS VERY IMPORTANT TO US, AND, BY DEFAULT, WE WILL ONLY DISCLOSE INFORMATION RELATED TO THE PATIENT'S **BILLING ACCOUNT** AND **MEDICAL CONDITIONS** TO THE **PATIENT** OR **LEGAL GUARDIAN.**

If you would like to provide additional contacts (other than the patient or legal guardian) that Foot and Ankle Center of Frisco/Plano can disclose this information, please complete the field below. In addition, please choose the person you would like our office to list as your **Emergency Contact** in the event emergency situation was to take place.

_____	_____	_____
CONTACT NAME	RELATIONSHIP TO PATIENT	CONTACT PHONE NUMBER

MY PREFERRED METHOD OF COMMUNICATION REGARDING MY **MEDICAL CONDITION** IS INDICATED BELOW (CHECK ONE)

☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE ☐ MAILED LETTER ☐ EMAIL

USE OF ELECTRONIC COMMUNICATION FROM FOOT AND ANKLE CENTER OF FRISCO/PLANO TO PATIENT

FOOT AND ANKLE CENTER OF FRISCO/PLANO OFFERS YOU A CONVENIENCE TO COMMUNICATE ELECTRONICALLY WITH YOU UNDER THE TERMS AND CONDITIONS OUTLINED BELOW. IF USING YOUR WORK EMAIL, PLEASE CONSIDER THE PRIVACY IMPLICATIONS THAT YOUR EMPLOYER MAY HAVE THE RIGHT AND/OR ABILITY TO REVIEW ALL EMAILS RECEIVED AT YOUR WORK ADDRESS.

☐ **YES**, I WANT FOOT AND ANKLE CENTER OF FRISCO/PLANO TO COMMUNICATE WITH ME ELECTRONICALLY. MY EMAIL ADDRESS IS _____

☐ **NO,** I DO NOT WANT FOOT AND ANKLE CENTER OF FRISCO/PLANO TO USE ELECTRONIC COMMUNICATIONS AS A WAY OF COMMUNICATING MY INFORMATION TO ME.

TERMS AND CONDITIONS:

1. The patient is responsible to notify Foot and Ankle Center of Frisco/Plano promptly of any changes to his/her email address.
2. All electronic communications are considered a part of your medical record and are recorded. Those who have access to your medical record also have access to the email messages sent to you.
3. Foot and Ankle Center of Frisco/Plano will not share your email address with anyone unauthorized to view your medical record.

_____	_____	_____
PATIENT'S NAME (PLEASE PRINT)	**PATIENT'S SIGNATURE**	**DATE**

FOOT AND ANKLE CENTER OF FRISCO/PLANO

Please Print **Date:**_____

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information to **The Foot and Ankle Center of Frisco/Plano**.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release is as follows:

□ Complete Records	□ History & Physical	□ Progress Notes
□ Care Plan	□ Lab Reports	□ Radiology Reports
□ Pathology Reports	□ Treatment Record	□ Operative Reports
□ Hospital Reports	□ Medication Record	□ Other (Please specify below)

Release my protected health information to the following entity:

Name: **Foot and Ankle Center of Frisco/Plano**

Address: **5375 Coit Road, Suite 100**

City, State, Zipcode: **Frisco, TX 75035**

_____ _____

Patient Name **Patient Signature**

_____

Date

FOOT AND ANKLE CENTER OF FRISCO/PLANO

Please Print **Date:**_____

CONSENT FOR TREATMENT

I, _____, hereby give my consent for medical treatment by the physician of Foot and Ankle Center of Frisco/Plano to myself or my dependent.

_____
Patient/Parent or Guardian Name **Printed**

_____ _____
Patient/Parent or Guardian Name **Signature** Date

I may revoke consent for any or all of the above initialized items at any time in writing. I certify that all information provided to Foot and Ankle Center of Frisco/Plano is correct.

_____ _____
Patient/Parent or Guardian Name **Signature** Date

FOOT AND ANKLE CENTER OF FRISCO/PLANO

Please Print **Date:**_____

Patient Photograph Release Form

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

Photograph Consent and Release:

I hereby acknowledge that I have been advised that photographs will be taken of my feet. The photographs will be taken by one of the members of the Foot and Ankle Center of Frisco/Plano medical staff. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of insurance pre-authorization, office and hospital medical charts, and any necessary medical treatment.

I hereby give additional consent to the Foot and Ankle Center of Frisco/Plano to use my photographs under the following conditions:

(Please initial) _____ I authorize my photographs to be used for the purposes of: Medical Seminars, website publication and/or office photo albums. All efforts will be made to ensure patient anonymity and confidentiality. No names or identifying references will be made in conjunction with published photography.

Patient's Signature: _____ **Date:** _____

FOOT AND ANKLE CENTER OF FRISCO/PLANO

Please Print **Date:**_____

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the Blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No"

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? **Yes No**

2. Do you experience any pain at rest in your lower leg(s) or feet? **Yes No**

3. Do you experience foot or toe pain that often disturbs your sleep? **Yes No**

4. Are your toes or feet pale, discolored, or bluish? **Yes No**

5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)? **Yes No**

6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? **Yes No**

7. Have you suffered a severe injury to the leg(s) or feet? **Yes No**

8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? **Yes No**

Patient Signature:_____

Physician Signature:_____ Date :_____