

FOOT AND ANKLE CENTER OF PLANO AND FRISCO

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 fees. I authorize the doctor O1 Foot and Ankle Center of 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 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 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 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 PLANO AND FRISCO

Name: _____

Date: _____

Have you had/been treated for:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Corns/Calluses | <input type="checkbox"/> Warts | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Leg or Foot Ulcers | <input type="checkbox"/> Fungal Nails | <input type="checkbox"/> Ingrown nails |
| <input type="checkbox"/> Broken foot bone(s) | <input type="checkbox"/> Neuroma | <input type="checkbox"/> Foot numbness |
| <input type="checkbox"/> Hammer/Mallet toes | <input type="checkbox"/> Broken Ankle | <input type="checkbox"/> Ankle sprain |
| <input type="checkbox"/> Cramps in legs/feet | <input type="checkbox"/> Bunions | <input type="checkbox"/> Flat feet |
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Arch pain | <input type="checkbox"/> High arch feet |
| <input type="checkbox"/> Gait (walking) problems | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Heel pain |
| <input type="checkbox"/> Childhood foot problems | <input type="checkbox"/> In-Toeing | <input type="checkbox"/> Toe walking |
| | <input type="checkbox"/> Rash | <input type="checkbox"/> 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:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart attack | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> A Heart Condition |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Eyes: Glaucoma/MacularDeg. |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Keloid/ Thick Scar |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing/Ear Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nerve Disorder | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Dark Urine | <input type="checkbox"/> Chronic Lt. Stool | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> 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?
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- | | | | | |
|-------|-------|----------|-------------|-------|
| _____ | _____ | 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..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other antibiotics (list below)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Empirin, Tylenol (if yes, circle)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Aspirin, Advil, Aleve, or Motrin (circle)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Celibrex, Bextra, Vioxx (circle)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other pain remedies (list below)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Morphine..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Codeine..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Demerol..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other narcotics (list below)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Novocaine..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other anesthetics (list below)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Sulfa drugs..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Adhesive tape..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Shrimp, Iodine, or Merthiolate..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Any other drugs or medications..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Others: _____
 Anything else that you want to tell the doctor? Yes No

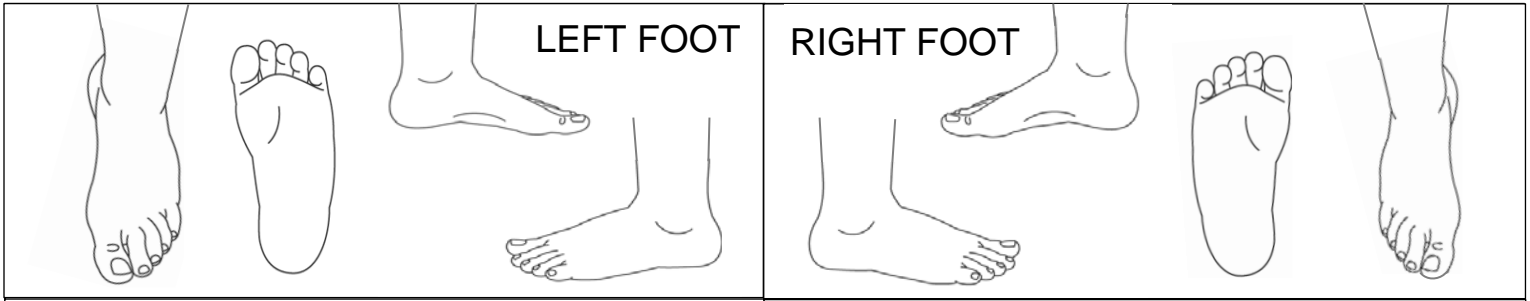
Illnesses / Explanations: _____

FOOT AND ANKLE CENTER OF PLANO AND FRISCO

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

For Doctor's Use – Observations & Comments

Patient was assisted in completion of this record by or was unable to complete with the help of: _____ in Spanish _____

Translation was done by _____

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 PLANO AND FRISCO

Name: _____ 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 and Plano is allowed to disclose this type of information, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. 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
<input type="checkbox"/> BILLING ACCOUNT INFORMATION	<input type="checkbox"/> MEDICAL CONDITION INFORMATION	<input type="checkbox"/> EMERGENCY CONTACT

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

HOME PHONE
 WORK PHONE
 CELL PHONE
 MAILED LETTER
 EMAIL

IF THE ABOVE METHOD OF COMMUNICATION IS BY PHONE, PLEASE CHECK THE APPROPRIATE BOX BELOW (CHECK ONE):

LEAVE A MESSAGE WITH DETAILED INFORMATION.

 LEAVE A MESSAGE WITH A CALL-BACK NUMBER ONLY.

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

FOOT AND ANKLE CENTER OF FRISCO AND 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 AND PLANO TO COMMUNICATE WITH ME ELECTRONICALLY. MY EMAIL ADDRESS IS _____

NO, I DO NOT WANT FOOT AND ANKLE CENTER OF FRISCO AND 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 and 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 and Plano will not share your email address with anyone unauthorized to view your medical record.

PATIENT'S NAME (PLEASE PRINT)	PATIENT'S SIGNATURE	DATE
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FOOT AND ANKLE CENTER OF PLANO AND FRISCO

Name: _____

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 : _____

FOOT AND ANKLE CENTER OF PLANO AND FRISCO

Name: _____

Date: _____

**REQUEST FOR RELEASE OF MEDICAL RECORDS
FROM**

**TO:
Foot & Ankle Center of Plano/Frisco**

**Horst P. Knapp, DPM
Mojgan Tavakoli, DPM
Anthony J. Brockington, DPM
Rebecca Wiesner, DPM**

**Podiatric Medicine and Surgery
5375 Coit Road, Suite 100
Frisco, Texas 75035
Phone: (972) 712-7773
Fax: (972) 712-3134**

Patient's Signature: _____

Patient's Name: _____

Address: _____

City: _____

State & Zip: _____

Birthday: _____

Date: _____

FOOT AND ANKLE CENTER OF PLANO AND FRISCO

Name: _____

Date: _____

CONSENT FOR TREATMENT

I hereby give my consent for medical treatment by the physician the direction of the physician of Foot and Ankle Center of Plano and Frisco 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 Plano and Frisco is correct.

Patient/Parent or Guardian Name **Signature**

Date