

PLEASE PRINT

PATIENT LAST NAME: _____ FIRST NAME _____ MI _____ DATE OF BIRTH: ____/____/____ AGE: _____

ADDRESS: _____ APT _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____

*****CIRCLE WHICH NUMBER YOU PREFER TO USE FOR REMINDER CALLS*****

SEX M F MARITAL STATUS _____ DRIVER'S LICENSE # _____ SOCIAL SECURITY # _____ - _____ - _____

EMPLOYER NAME/ADDRESS _____ OCCUPATION _____

EMERGENCY CONTACT _____ PHONE# _____ RELATIONSHIP TO PATIENT _____

EMAIL _____ PREFERRED LANGUAGE _____ ENGLISH _____ SPANISH _____ OTHER _____

RACE _____ NATIVE AMERICAN _____ AFRICAN AMERICAN _____ ASIAN _____ WHITE _____ HISPANIC _____ OTHER _____ UNREPORTED/REFUSED _____

PHARMACY _____ PHONE # _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID# _____ GROUP/POLICY _____

REFERRAL REQUIRED: ____YES ____NO (PATIENT RESPONSIBLE TO OBTAIN REFERRALS)

NAME OF POLICY HOLDER _____ DATE OF BIRTH ____/____/____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____ ID# _____ GROUP/POLICY _____

NAME OF POLICY HOLDER _____ DATE OF BIRTH ____/____/____ RELATIONSHIP TO PATIENT _____

IS THIS A WORK RELATED INJURY? YES OR NO IF YES, DATE OF ACCIDENT ____/____/____ CLAIM # _____

PLACE OF ACCIDENT _____ ADJUSTOR _____ PHONE NUMBER _____

COMPLETE THIS SECTION ONLY IF THE PATIENT IS A MINOR

RESPONSIBLE PARTY NAME _____ RELATIONSHIP TO MINOR _____

ADDRESS _____ APT _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____

REFERRAL SOURCE

____FAMILY/FRIEND ____INSURANCE PROVIDER LIST ____INTERNET SEARCH ____PHYSICIAN ____OTHER

DOCTOR _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN _____ PHONE# _____ DATE LAST SEEN _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

LIST ANY SURGERIES AND/OR HOSPITALIZATIONS

PROCEDURE	DATE

LIST ALL MEDICATIONS (BOTH PRESCRIBED AND OVER THE COUNTER) AND SUPPLEMENTS

MEDICATION	FREQUENCY	MEDICATION	FREQUENCY

PATIENT NAME: _____

D.O.B. ____ / ____ / ____

ALLERGIES: PLEASE LIST

ANTIBIOTICS: PENICILLIN SULFA KEFLEX

PAIN MEDS: CODEINE MORPHINE ASPIRIN NSAIDS

OTHER: SHELLFISH IODINE ADHESIVE TAPE GENERAL / LOCAL ANESTHETIC.

REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT APPLY.

CONSTITUTIONAL SYMPTOMS: CHILLS DIZZINESS FEVER FATIGUE

EENT: BLURRED VISION / CHANGES IN VISION / CHANGE IN HEARING/RINGING IN EARS / DIFFICULTY WITH SWALLOWING / SINUS PROBLEMS OR INFECTIONS / SORE THROAT/COUGH

CARDIOVASCULAR: CHEST PAIN / HEART ATTACK / SHORTNESS OF BREATH / SWELLING OF FEET AND/OR ANKLES / HIGH/LOW BLOOD PRESSURE / MITRAL VALVE PROLAPSE / PACEMAKER

GASTROINTESTINAL: CONSTIPATION / DIARRHEA / GERD / NAUSEA / REFLUX/ HEPATITIS / CIRRHOSIS / PANCREATITIS

GENITOURINARY: RENAL (KIDNEY) DISEASE / FREQUENT URINATION / STD / PROSTATE DISEASE

SKIN DISORDERS: RASH/ITCHING / CHANGE IN SKIN COLOR / CHANGE IN HAIR / HIVES / PSORIASIS / NON-HEALING WOUNDS / EASY SCARRING

HEMATOLOGIC/LYMPHATIC: POOR CIRCULATION / PVD / LEG OR CALF PAIN / REST PAIN / VEIN PROBLEMS / SWELLING VARICOSE VEINS / PHLEBITIS / LEG ULCERS / BLOOD CLOTS / DVT/ PAST TRANSFUSIONS / LEUKEMIA / LYMPHOMA / HIV/AIDS / SICKLE CELL / CANCER / RADIATION TREATMENT

ENDOCRINE: DIABETES /IF DIABETIC, HOW LONG _____ WHAT TYPE _____ CONTROLLED **Yes/No**
THYROID DISEASE / HORMONAL PROBLEMS / EXCESSIVE THIRST OR URINATION

NEUROLOGICAL: BURNING / TINGLING / NUMBNESS / PARALYSIS / TREMORS / STROKE / HEAD INJURY / MULTIPLE SCLEROSIS / CEREBRAL PALSY

RESPIRATORY: ASTHMA / BREATHING DIFFICULTY / COPD / LUNG DISEASE / TUBERCULOSIS / SLEEP APNEA

MUSCULOSKELETAL: JOINT PAIN / MUSCLE TENDERNESS / MORNING STIFFNESS / WEAKNESS / DIFFICULTY WALKING /RHEUMATOID ARTHRITIS / OSTEOARTHRITIS / JOINT REPLACEMENT / FIBROMYALGIA / OSTEOPOROSIS / GOUT

PSYCHOLOGICAL: ANXIETY / DEPRESSION / MEMORY LOSS/CONFUSION / SUICIDAL THOUGHTS / CHEMICAL DEPENDENCY

SOCIAL & FAMILY HISTORY

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE

FREQUENCY: _____ #DRINKS PER _____ MONTH/ WEEK/ DAY

USE OF TOBACCO: NEVER NO LONGER USE CURRENT USER

FREQUENCY: _____ #CIGARETTES PER _____ MONTH/ WEEK/ DAY

USE OF RECREATIONAL DRUGS: NEVER NO LONGER USE CURRENT USER

FREQUENCY: _____ #TIMES PER _____ MONTH/ WEEK/ DAY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE

STROKE CORONARY ARTERY DISEASE THYROID RHEUMATOID ARTHRITIS

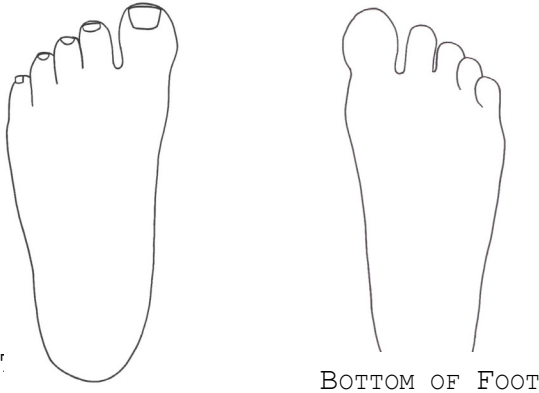
OTHER _____

Patient Height _____ Weight _____ Shoe Size _____

Current problem(s): If you have more than one problem -please request additional sheet(s)

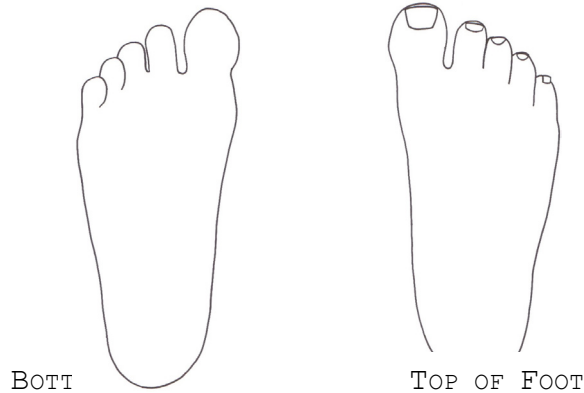
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW USING X'S.

LEFT FOOT



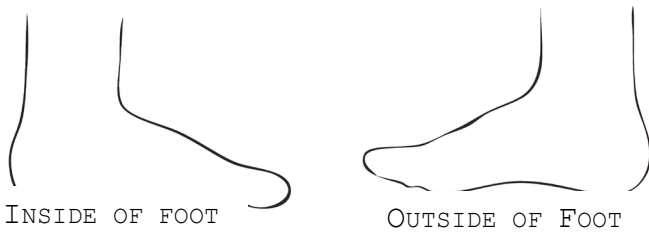
BOTTOM OF FOOT

RIGHT FOOT



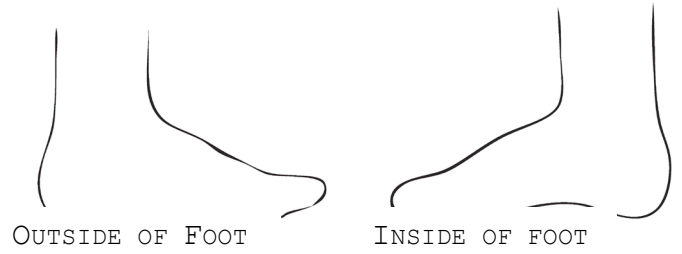
BOTT

TOP OF FOOT



INSIDE OF FOOT

OUTSIDE OF FOOT



OUTSIDE OF FOOT

INSIDE OF FOOT

PROBLEM(S) : _____

WAS THIS PROBLEM CAUSED BY AN INJURY? YES NO

(DESCRIBE) _____

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING
 RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES

RESTING DRESS SHOES HIGH HEELS WORSE AT NIGHT OR SLEEPING

ANY CLOSED TOE SHOE RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?

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 paid.

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, and toe separators, i.e., anything that is given to you in this office that your carrier may not pay).

Consent to Treat and Financial Responsibility

I hereby authorize Metroplex Foot and Ankle, LLP to render medical services and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

Patient Name (Please Print) _____

Signature of Patient, Parent, or Legal Guardian _____ **Date** _____

Payment is expected at the time of your visit. We accept cash, check or credit cards. As our patient you are responsible for all payments of any deductible, co-insurance, co-pay or non-covered services. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. As our patient you are responsible for any unpaid bills 60 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 Metroplex Foot and Ankle, L.L.P. to release medical information pertinent to filing of an insurance claim for me. There is a service fee of \$25 for all returned checks. I understand that Metroplex Foot and Ankle Physicians may have financial interests in North Garland Surgery Center, Breckenridge Surgery Center, Millennium Pharmaceuticals and Health Scripts Pharmacy.

Patient Name (Please Print) _____

Signature of Patient, Parent, or Legal Guardian _____ **Date** _____

ACKNOWLEDEMENT OF RECEIPT OF PRIVACY NOTICE

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form to acknowledge that you have been provided with a copy of our notice.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

PATIENT NAME (PLEASE PRINT)

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN _____ **DATE** _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

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

I REQUEST THAT ALL COMMUNICATIONS TO ME (BY PHONE, MAIL OR OTHERWISE) BY METROPLEX FOOT AND ANKLE, LLP PHYSICIANS AND STAFF BE HANDLED IN THE FOLLOWING MANNER:

FOR WRITTEN COMMUNICATIONS OTHER THAN HOME ADDRESS:

FOR VERBAL COMMUNICATIONS CALL: _____ **MAY WE LEAVE A MESSAGE?** YES NO

USE OF ELECTRONIC COMMUNICATIONS FROM METROPLEX FOOT AND ANKLE, LLP TO PATIENT

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

YES, I want Metroplex Foot and Ankle, LLP to communicate with me electronically.
EMAIL _____

No, I do not want Metroplex Foot and Ankle, LLP to use electronic communications as a way of communicating my information to me.

METROPLEX FOOT AND ANKLE, LLP EMAIL GUIDELINES

- 1. THE PATIENT IS RESPONSIBLE TO NOTIFY METROPLEX FOOT AND ANKLE PROMPTLY OF ANY CHANGES TO HIS/HER EMAIL ADDRESS.
- 2. ALL ELECTRONIC COMMUNICATIONS ARE CONSIDERED A PART OF YOUR MEDICAL RECORDS AND ARE RECORDED. THOSE WHO HAVE ACCESS TO YOUR MEDICAL RECORD ALSO HAVE ACCESS TO THE EMAIL MESSAGES SENT TO YOU.
- 3. METROPLEX FOOT AND ANKLE WILL NOT SHARE YOUR EMAIL ADDRESS WITH ANYONE UNAUTHORIZED TO VIEW YOUR MEDICAL RECORD.

CONSENT AND AGREEMENT

I HAVE CAREFULLY REVIEWED THIS DOCUMENT AND AGREE TO FULLY COMPLY WITH THE GUIDELINES DEFINED HEREIN FOR ELECTRONIC COMMUNICATION FROM METROPLEX FOOT AND ANKLE. I UNDERSTAND THAT THIS SERVICE WILL BE OFFERED AT NO CHARGE.

Patient Name (please print) _____

Signature of Patient, Parent or Legal Guardian _____ **Date** _____

FOR PRACTICE USE ONLY

Practice: _____ Accepts _____ Denies _____
Privacy Officer Signature: _____ Date _____

METROPLEX

Foot & Ankle, LLP

METROPLEX FOOT AND ANKLE, L.L.P.

Timothy C. Abigail, D.P.M.

Robert T. Angelier, D.P.M.

Brian E. De Yoe, D.P.M.

Scott E. Smith, D.P.M.

MISSED APPOINTMENT POLICY

POLICY:

To notify patients of a possible financial penalty for failure to cancel a scheduled appointment our office will document in the electronic medical record when a patient no shows for an appointment or cancels an appointment on short notice.

Failure to give 24 hour notice of cancellation of an appointment or no-showing for an appointment can result in a charge of \$25.00 to the patient's account. This charge cannot be billed to the insurance company. Medical care will not be withheld for a medical emergency.

PROCEDURE

CHECK ONE BOX. SIGN & DATE BELOW.

YES. I understand the Missed Appointment Policy.

I have been informed that a \$25 charge will be applied to my account when I miss appointments without giving proper notice. I understand that this charge cannot be billed to an insurance company. I agree to be personally and fully responsible for payment.

NO. I have decided not to receive services.

Date

Signature of patient or person acting on patient's behalf

Richardson/Garland

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Suite 106
Richardson, TX 75082
214-217-3668 • Fax 214-217-3669

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6330 Broadway Blvd.,
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3600 Gaston Avenue,
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