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 NAM,E/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 CIRCLE 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

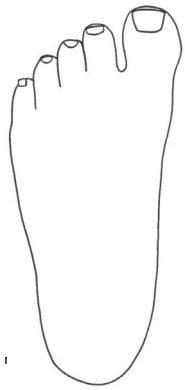
USE OF RECREATIONAL DRUGS: ☐NEVER ☐NO LONGER USE ☐CURRENT USER
FREQUENCY: _____#TIMES PER _____ MONTH/ WEEK/ DAY

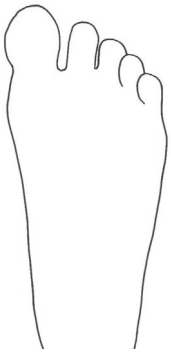
DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐CANCER ☐HEART DISEASE ☐HIGH BLOOD PRESSURE
☐STROKE ☐CORONARY ARTERY DISEASE ☐THYROID ☐RHEUMATOID ARTHRITIS
☐OTHER_____

Patient Height _____ Weight _____ Shoe Size _____
Current problem(s): If you have more than one problem –please request additional sheet(s)

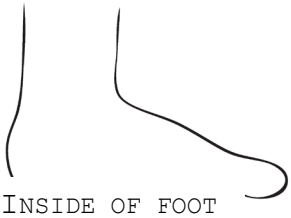
WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW USING X'S.

LEFT FOOT





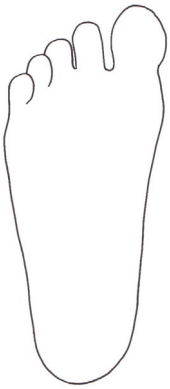
BOTTOM OF FOOT



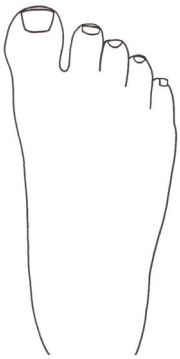
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP 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).

P

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 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.

Board Certified Podiatric Surgeons
Diplomats, American Board of Podiatric Surgery
Fellows, American College of Foot and Ankle Surgeons

MISSED APPOINTMENT POLICY

POLICY:

To notify patients of a 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 will result in a charge of $35.00 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 $35 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**

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

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Suite D-2
Garland, TX 75043
972-226-0774 • Fax 214-217-3669

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Dallas, TX 75246
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www.dallasfoot.com