



# Welcome Back!

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: **M / F** SS#: \_\_\_\_\_

Address: \_\_\_\_\_  
Street (Apt. #) City / State / Zip Code

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Preferred # Home / Cell / Work

E-mail Address: \_\_\_\_\_ Marital Status: (**Circle one**) **S M D W**

Student - **FT / PT** Employed - **FT / PT** - Unemployed - Retired - Disabled

**Parent or Person responsible for account: (If patient is a minor, under 18 years of age.)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address if different from above: \_\_\_\_\_ Relationship: \_\_\_\_\_

Should the patient be a minor, a legal guardian must be present at every appointment in order to have services rendered.

**Primary Care Physician Name:** \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

**Emergency Contact:** (Please include a phone number other than what is listed above)

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**I Authorize ONLY the following person/s to call and or request information about my PHI (Protected Health Information).**

Patient Only Other: (name & relation to patient) \_\_\_\_\_

**Insurance** (Check one)

\_\_\_ My insurance HAS NOT changed since my last visit with Houston Foot Dr – Insurance Carrier: \_\_\_\_\_

\_\_\_ My insurance HAS changed – Insurance Carrier: \_\_\_\_\_ ID# \_\_\_\_\_  
Please provide a copy of your new insurance card.

\_\_\_ No insurance. I will be Self Pay. We accept all Major Credit Cards / Debit Cards / Cash / Checks and Care Credit  
WE DO NOT ACCEPT WORKERS COMPENSATION INSURANCE

**ALL INSURANCE INFORMATION MUST BE ACCURATE AND UP TO DATE. We DO NOT back-file previous visits. We must be notified of any changes before scheduled appointments or you will be responsible for services rendered. It is your responsibility to obtain a referral if one is required by your insurance. Unpaid/Denied claims will be your responsibility.**

By signing below, I acknowledge the above information to be true to the best of my knowledge. I authorize Houston Foot Dr. to release any of my information required to process my claims. I have read and understand Houston Foot Dr.'s office policy (REV19). I am aware I may obtain a copy from the office at my request or online at [www.houstonfootdr.com](http://www.houstonfootdr.com).

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Patient Clinical Information

Reason for visit: \_\_\_\_\_ When did it begin? \_\_\_\_\_

Have you seen another doctor for this? Yes / No If yes, who and when? \_\_\_\_\_

Was this problem caused by an accident or work related injury? (Circle one) Accident / Work Injury
We do not accept Worker Comp but will gladly provide you with necessary paper work to submit your own claims.

Occupation: \_\_\_\_\_ Does your job require for you to be on your feet more than 4 hours? Yes / No

Exercise: (Circle one) Yes / No Smoking Status: Current / Former / Never Drinking Status: Yes / No

Shoe size: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please list any medications you are allergic to or have had adverse side effects to.

\_\_\_\_\_

Please list any medications you are currently taking prescribed or over the counter and the reason\*: (include dosage)

\_\_\_\_\_

\* The above medications are true and complete. Omissions are unintentional and will be corrected at my responsibility. Interactions caused by my omission, is not the responsibility of HFD.

How would you like your prescriptions? (Circle one) Print my prescription Send to my Pharmacy

Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please check any previous and current medical conditions.

- ADD/ADHD, Diabetes, Liver Disorder, Alzheimer's Disease, DVT, Lung Disorder, Ankle Swelling, GERD, Neuropathy, Arthritis, Gout, Parkinson, Asthma, Headache/Migraine, Poor Circulation, Atrial Fibrillation, Hepatitis, Seizures, Blood Clots, High Blood Pressure, Shortness of Breath, Cancer, High Cholesterol, Stroke, Cardio Vascular Disease, HIV Positive, Thyroid Disorder, COPD, Kidney Disorders, Ulcers, Depression/Anxiety

Other conditions not listed above: \_\_\_\_\_

\_\_\_\_\_

Past surgical History: (Please include the year performed) \_\_\_\_\_

\_\_\_\_\_

\*The above information is true and complete. Omissions are unintentional and will be corrected at my responsibility.