Welcome to Our Office!

PLEASE PRINT CLEARLY

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.

How were you referred to our office? (Circle one)

My Doctor Friend/Family Internet Through Insurance Drive By I am a Previous Patient

Doctor's Name: _____ Phone #: _____

Primary Care Physician Name: _____ Phone #: _____

Address: _____

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) _____

Will you be using Insurance? (Circle one)

YES: Insurance Carrier: _____ ID# _____ Group#: _____

Policy Holder: _____ DOB: _____ Relationship _____

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.

NO: I will be Self Pay / Pay out of pocket

* For your convenience, our office accepts all Major Credit Cards / Debit Cards / Cash / Checks and Care Credit
WE DO NOT ACCEPT WORKERS COMPENSATION INSURANCE

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.

Patient / Guardian Signature: _____ Date: _____

Houston Foot Dr.

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 <u>previous and current</u> medical conditions.

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

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.**