



Welcome to Our Office!

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:** _____



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.

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