

PLEASE PRINT

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Res. Phone: _____ Sex: M F Marital Status: M S W D
Employed by: _____ Work Phone: _____ Occupation: _____
Address: _____
Social Security No.: _____ Drivers License: _____
E-mail Address: _____
Pharmacy Phone: _____ Pharmacy Fax: _____

INSURANCE INFORMATION

Medical Insurance: _____ Group/Policy: _____ ID#: _____
Other Insurance: _____ Group/Policy: _____ ID#: _____
Is this a work related injury? Yes No If Yes, Date of Accident: _____
Place of Accident: _____ Claim #: _____
Claims Adjustor: _____ Phone No.: _____ Insurance Carrier: _____
Address: _____

RESPONSIBLE PARTY (SELF / NAME OF PERSON INSURANCE IS CARRIED BY OR PRIMARY CARRIER OF THE INSURANCE)

Name of Guarantor (if other than patient): _____ Date of Birth: _____ Age: _____
Employed by: _____ Work Phone: _____ Social Security No.: _____

EMERGENCY CONTACT

Relative or Friend not living with you: _____ Phone: _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

Name: _____ Address: _____
Internet Yellow Pages (Which Directory?): _____ Other: _____

MEDICAL INFORMATION

Family Doctor: _____ Last Visit: _____
Address: _____ Phone No.: _____
Former Podiatrist/Foot Surgeon: _____
My Foot Problem is: Please describe your foot problem and how long you have had it:

1. Are you allergic to any of the following?

Local Anesthetics Penicillin Tape Aspirin Iodine
 Antibiotics Other: _____

2. Are you in good health? Yes No

3. Are you taking any medications? Please list and amount: _____

4. Have you had any serious illness or operation? Yes No

List surgery and date: _____

5. Check any of the following, which applies to you:

- | | | | | |
|------------------------------------|---|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Circulation | <input type="checkbox"/> Gastric Ulcers | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatic Fever /
Matro Valve Prolapse |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes
How long and is it controlled well?
_____ | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Varicose Vein |

6. Are you now taking or have you recently taken any blood-thinning medications? Yes No

7. Do you have bleeding tendencies? Yes No 8. Do you have leg cramps? Yes No

9. Height: _____ Weight: _____ Shoe Size: _____

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 payable.

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

PLEASE SIGN BELOW

I authorize use of this form on all my insurance submissions and release of information to all my insurance companies. I acknowledge responsibility for payment of any deductibles, co-insurance, and unauthorized or non-covered services. I accept responsibility for any unpaid bills sixty 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 the doctors of Metroplex Foot & Ankle, L.L.P. to act as my agents in helping me obtain payment from my insurance company. I request payment of my insurance benefits be made directly to Metroplex Foot & Ankle, L.L.P. for any services furnished to me by my physician. I permit a copy of this authorization to be used in place of the original. I hereby give permission to physicians of Metroplex Foot & Ankle, L.L.P. to examine and administer treatment after consultation and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Metroplex Foot & Ankle, L.L.P. and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature of Patient or Legal Representative: X: _____ Date: _____