

Thank you for choosing our office. Please PRINT all information. All information is strictly **confidential**.

NAME OF PATIENT _____ AGE _____ DATE OF BIRTH _____ Sex: M F

HOME ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ MOBILE _____ EMAIL _____

CONTACT PREFERENCE (PLEASE CIRCLE): _____ HOME PHONE / MOBILE/ EMAIL _____

PATIENT SOCIAL SEC #. _____ DRIVER LIC. _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____ MARITAL STATUS (CIRCLE): **M S D W**

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT _____
NAME RELATIONSHIP PHONE

PHARMACY NAME AND ADDRESS: _____

REFERRED BY (PLEASE BE SPECIFIC): Doctor _____ Patient/friend _____ Insurance
 Ad/Magazine _____ Phone book (which directory?) _____
 Google Yahoo Bing online yellow pages other _____

INSURANCE

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: _____

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

Name of Insured (if other than patient): _____ Date of Birth: _____ Age: _____

Employed by: _____ Work Phone: _____ Social Security No.: _____

Address if different from patient: _____

MEDICAL

WHAT IS YOUR FOOT/ANKLE PROBLEM? _____ DURATION? _____

ANY PRIOR TREATMENT? _____ BY WHOM? _____ L or R FOOT? _____

PLEASE LIST ALL MEDICATIONS YOU TAKE: _____

DO YOU HAVE ANY ALLERGIES? None Known LATEX/RUBBER DYES / IODINE CODEINE LOCAL ANESTHETICS
 PENICILLIN ASPIRIN SULFA TAPE OTHER _____

FAMILY DOCTOR: _____ DATE OF LAST EXAM: _____

FORMER PODIATRIST: _____

PATIENT HISTORY:

1. Are you in good health? _____ Yes No


2. Do you have now, or have you ever had: **CIRCLE**

- | | | | | |
|--------------------|--------------------|---------------------|-----------------------|---------------------------------------|
| ANEMIA | CHEST PAIN | HEART TROUBLE | PASSING OUT | STOMACH ULCER |
| ARTHRITIS | COUNSELING | HEPATITIS | PHLEBITIS / CALF PAIN | STROKE |
| ASTHMA | DIABETES | HIGH BLOOD PRESSURE | POOR CIRCULATION | THYROID PROBLEM |
| ANKLE/LEG SWELLING | EMPHYSEMA | HIV / AIDS | PROLONGED BLEEDING | TUBERCULOSIS (TB) |
| BLOOD PROBLEM | EPILEPSY / SEIZURE | KIDNEY PROBLEM | PRONE TO INFECTION | UNEQUAL LEG LENGTH |
| BLOOD TRANSFUSION | FOOT ULCER | LEG CRAMPS | PSYCHIATRIC CARE | VARICOSE VEINS |
| BRONCHITIS | GOUT | LIVER PROBLEM | RHEUMATIC FEVER | WEAK ANKLES |
| BRUISE EASILY | HEARING PROBLEM | LOW BACK PAIN | SHORT OF BREATH | <input type="checkbox"/> OTHER: _____ |
| CANCER | HEART MURMUR | LOW BLOOD SUGAR | SICKLE CELL | _____ |

3. **FEMALES:** Any chance you might be pregnant? Yes No

4. Are you taking or have you recently taken blood-thinning medications including aspirin or ibuprofen? Yes No

5. **PREVIOUS HOSPITALIZATION / SURGERY / ILLNESS (list surgery and date):**

FAMILY HISTORY:  circle diabetes cancer bleeding TB high blood pressure heart trouble
(blood relatives) stroke hepatitis HIV (AIDS) OTHER _____

SOCIAL HISTORY

Do you smoke? Y / N Cigarettes / Pipe / Cigar Amount/day _____ # years _____ Quit date _____
Do you drink alcohol? Y / N Type _____ Amount/day _____ # years _____ Quit date _____
Recreational drugs? Y / N Type _____ Amount/day _____ # years _____ Quit date _____

Height: _____ Weight: _____ Shoe Size: _____

 **NOTE: IF MY HEALTH OR MEDICATION CHANGES, I WILL NOTIFY THE DOCTOR AT MY NEXT VISIT**

REFERRAL POLICY

If your insurance is a part of a 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 Jeffrey M. Radack, DPM, PLLC to act as my agent in helping me obtain payment from my insurance company. I request payment of my insurance benefits be made directly to Jeffrey M. Radack, DPM, PLLC 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 Jeffrey M. Radack, DPM, PLLC 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 Jeffrey M. Radack, DPM, PLLC and Texas Foot & Ankle Clinic 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: _____ Date _____



Texas Regional Foot and Ankle Clinics

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In our efforts to comply with the **Health Insurance Portability and Accountability Act (HIPAA)**, we need to be certain that we guard your privacy. Your information will only be released to your insurance company for processing your claims unless you name someone below on the lines provided with whom we are allowed to discuss your case, leave messages regarding appointments or discuss your billing. If you do not want us to discuss this with anyone, please fill out your name and date of birth and mark through the area for the names for information to be released to and answer the last question and sign and date the form.

I, _____, with date of birth _____,

Authorize the specific medical information listed below to be released to:

Please check the following medical information that the above listed person(s) may receive on your behalf:

- _____ **ALL** health care information
_____ **ONLY** test results (including labs/xrays, etc.)
_____ **ONLY** medication(s) information
_____ **ONLY** appointment information

Please circle your response to the following questions:

May we leave a message concerning appointments/treatments with a co-worker?

YES NO N/A

May we leave a message concerning appointments/treatments on a voicemail at work?

YES NO N/A

May we leave a message concerning appointments/treatments on a voicemail at home and or cell phone?

YES NO N/A

Please inform us in writing of any changes to the above information. This HIPPA form will be kept in your file along with your acknowledgement of receipt of the Notice of Privacy Practices.

Patient Signature/Parent/Legal Guardian

Date



Vascular Screening Questionnaire

Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Current or former smoker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Family member has peripheral artery disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> 50 years or older |
| <input type="checkbox"/> Heart attack or procedure to open an artery supplying your heart | |
-

Do you experience any of the following in your legs? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Pain with walking or other exercise, and gets better with rest | <input type="checkbox"/> Wounds that won't heal |
| <input type="checkbox"/> Legs tire but improve with rest | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Pain at night that improves with dangling leg over side of bed | <input type="checkbox"/> Foot or toe numbness or coldness |
| <input type="checkbox"/> Can't walk far | <input type="checkbox"/> Leg pain worse with laying down |
-

Do you experience any of the following in your legs? (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Aching/pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Heaviness | <input type="checkbox"/> Tiredness/fatigue |
| <input type="checkbox"/> Itching/ burning | <input type="checkbox"/> Varicose or spider veins |
| <input type="checkbox"/> Restless legs | <input type="checkbox"/> Sores, ulcers, wounds difficult to heal |
| <input type="checkbox"/> Discoloration/darkening below knee | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Episodes of redness or inflammation below knee | |