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

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

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	☐ 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: ☞ diabetes cancer bleeding TB high blood pressure heart trouble
(blood relatives) circle 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

Jeffrey M. Radack, D.P.M, F.A.C.F.A.S
Diplomate, American Board of Foot & Ankle Surgery
*8951 Collin McKinney Pkwy, Ste 603 McKinney, TX 75070
* 580 S. Denton Tap Rd, Ste 290 Coppell, TX 75019
P: 469-742-0406
F: 469-952-2806
www.TexasFootClinic.com

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