



PATIENT INFORMATION

Last Name First Name Middle Init Address City, State & Zip E-Mail Address Main Phone Alternate number Date of Birth Sex: M F Patient's SS# Marital Status Single / Married / Widowed / Separated / Divorced Race American Indian / Asian / African American / Pacific Islander / White Ethnicity Hispanic / Non-Hispanic Student Status Non-student / Full-time / Part-time Preferred Language If minor, who is responsible for payment Relationship Address City, State & Zip Guarantor's Date of Birth Emergency Contact Name Phone Relationship

INSURANCE INFORMATION

Employer Name Insurance Co. Name Policy Holder's Name Relationship to Insured Policy Holder's DOB Policy Holder's SS# Policy ID # Group # Secondary Ins Co. Name Policy Holder's Name Medicare # Medicaid # If your insurance requires referral who is your listed Provider

If we do not have a referral and/or authorization on file from your assigned provider, then payment is due at time of service. Please verify that we have your referral and/or authorization on file before your visit, if not you can reschedule until a referral or authorization is obtained.

PRIMARY CARE PHYSICIAN

Name Date Last Seen? City State Zip Phone Who may we thank for referring you? Relationship Primary Pharmacy Location

FINANCIAL POLICY OF THIS OFFICE

FEES ARE DUE AND PAYABLE UPON COMPLETION OF EACH AND EVERY VISIT, COPAYMENT INCLUDED. If you require surgery, a deposit will be required. If you have insurance, we will be happy to help you file the first claim. Your contract is between you and your insurance carrier; not your doctor and your insurance carrier. You will be personally responsible for any amounts not covered or paid by insurance for any reason.

I hereby authorize payment of insurance benefits to Brazos Valley Foot Care.

Patient's Signature X Date

Guarantor's Signature X Date

Preferred Method of Contact

May we leave lab, testing results, appointment reminders and surgical procedure dates on your home answering machine?

Yes No (Please Circle)

With whom do you allow us to share your health information, if you are unavailable?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

With whom may we discuss your account balance with?

Name: _____ Relationship: _____

May we contact you at your place of business regarding your account?

Yes No (Please Circle)

What is your preferred method of contact?

Home: _____

Cell: _____

E-mail: _____

If your insurance company denies your claim, may we have authorization to file an appeal on your behalf?

Yes No (Please Circle)

What is your primary language? _____

How were you referred to our office? _____

I certify that the information given above is true and correct. I understand that it is my responsibility to notify Brazos Valley Foot Care, PA of any changes to the above information.

Patient or Guardian Signature: _____ **Date:** _____

Brazos Valley Foot Care, PA ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

My signature at the bottom of this form authorizes payment for services rendered to myself or my dependant to be made directly to Brazos Valley Foot Care, PA. This authorization is valid until I notify Brazos Valley Foot Care, PA in writing that it is revoked.

I understand that I am responsible for giving “Brazos Valley Foot Care, PA” the correct insurance information at the time services are rendered. Brazos Valley Foot Care, PA agrees to bill your primary insurance carrier. *If you have more than one insurance, we will bill your secondary insurance one time as a courtesy. If payment is not received from your secondary within 45 days, the balance becomes your responsibility. All insurance information must be provided to our office, at the time of service.*

I understand that I am responsible for obtaining the proper referral and may be held responsible for charges not covered by my Insurance due to my failure to obtain the required referral.

I agree to pay for non-covered services under my insurance plan (services for which I have a policy exclusion).

I understand that Brazos Valley Foot Care, PA is not responsible for knowing if the group/physician is a participating provider with my insurance carrier.

We at Brazos Valley Foot Care, PA expect that all accounts should be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan, we will be charging a \$10 re-billing fee, for each statement that we mail. If you have made arrangements with our office, we will not charge the re-billing fee for statements sent. Your account will be turned over to collection if you do not fulfill the terms of your financial arrangements.

I understand that there is a \$25 fee for all returned checks.

I understand that if I do not call to cancel my appointment within 24 hours there will be a \$25 fee applied to my account.

I understand that I am responsible for all balances not paid by my insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties. I further understand that if this balance is turned over to an outside collection agency that I shall be liable for all costs of collection and any attorney fees and or court costs incurred by this office.

Patient or Patients Guardian or Legal Representative Signature

Date

Name of Patient or Guardian or Legal Representative

Relationship to patient

Brazos Valley Foot Care, PA

Brian Abbey DPM Eduardo Orihuela DPM Robert Aguilar DPM Julie Albert DPM Tyler Kearney DPM

History & Medical Information

1. Primary Care Physician: _____
 Phone Number: () _____ Date of Last Visit: _____

2. Treating Diabetic Physician: _____
 Phone Number: () _____ Date of Last Visit: _____

3. Height: _____ Weight: _____ Shoe Size: _____ B/P: _____ (For Nurse to fill in.)

4. Explain your foot/ankle problem: _____

5. When did pain/discomfort begin? _____
 Describe pain/discomfort: Burning Numbness Sharp Other: _____

6. What makes pain/discomfort better? _____

7. What makes pain/discomfort worse? _____

8. Has condition been treated? YES NO When and how: _____

9. Past Medical History:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other Arthritis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disorders | <input type="checkbox"/> Prostate Disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Nerve Disorders | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV/ Aids | <input type="checkbox"/> Neurologic | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other: _____ |

10. List or attach all medications/herbs/vitamins: None

What is your Pharmacy name? _____ Phone () _____

11. Allergies: None

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Shellfish
<input type="checkbox"/> Narcotic Agent/ Codeine	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Radiographic Contrast/ Dyes	

12. Surgical History:
 Have you had Surgery: YES NO
 Describe Surgery/Date: _____

13. Social History:
 Tobacco Use* Alcohol use Exercise Habits _____ * If Yes How Much? _____
 Caffeine Use Drug Use (Recreational, IV) Pregnant Nursing

14. Occupation/Job: _____

15. Family history: (list relationship of member(s) who have had problems)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatology	<input type="checkbox"/> Other Family History: _____		

Brazos Valley Foot Care, PA Review of Symptoms

1. Constitutional Symptoms:

Fevers Chills Sweats Weight Loss NONE

2. Head, Eyes, Ears, Nose and Throat: Do You...

Wear:	Contacts	Dentures	Eyeglasses	NONE
Have:	Double Vision	Cataracts	Dizziness	ringing in Ears
	Difficulty Swallowing	Neck Pain	Sore Throat	
	Nose Bleeds	NONE		

3. Cardiovascular:

Chest Pain/Heart Attack	Congestive Heart Failure	Heart Murmur	Palpitations
Swelling in Legs/Ankles	Leg Pain w/ Exercise	Cardiovascular Surgery	NONE

4. Hematological/Lymphatic (Blood):

Bleeding abnormalities	Anemia	Lump In Groin or Armpit	Lymphoma
Swollen Glands	NONE		

5. Respiratory:

Shortness of Breath	Emphysema	Cough	Bronchitis
Difficulty Breathing	Wheezing	Asthma	Previous Pulmonary Disease
TB (tuberculosis) Exposure or Treatment		Pneumonia	NONE

6. Gastrointestinal:

Nausea	Vomiting	Diarrhea	Constipation	Stomach Ulcers
Decrease in Appetite		Blood in Stool	Hepatitis	Acid Reflux
				NONE

7. Endocrine:

Often Thirsty	Often Urinating	Kidney Disease	Pancreatitis
Diabetes Mellitus	Prostate Problems	Thyroid Disorder	NONE

8. Musculoskeletal:

Tendonitis	Bursitis	Broken Bones	Arthralgia
Weakness Of limbs	Feeling Weak	Joint Pain	NONE

9. Nervous System:

Migraines	Seizures	Strokes	Nervous Disorders
Ataxia (loss of balance)	Aphasia(loss of speech)	Confusion	Fainting
Neuropathy (loss of sensation)	Speech Difficulties		NONE

10. Integumentary:

Rash	Skin Ulcers	Lesions	Sensitivity to Sun
Change in Skin Color	Growth on Skin	Recurrent Infections	Cracking of the Skin
Eczema	Keloid	Hair Loss	NONE

11. Psychiatric History:

Nervousness	Tension	Depression	NONE
-------------	---------	------------	------

To the best of my knowledge, the questions on this form have been accurately answered.

Patient/Guardian Signature: _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. **

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

**** *Packets are available at the front window.***

Name _____

Date _____

WELCOME TO OUR OFFICE

THANK YOU FOR CHOOSING US FOR YOUR FOOT CARE!

How did you find out about us? Please mark the block that applies and tell us who referred you!

Your Insurance?

The Phone Book - Which one?



Verizon



AreaWide



Names&Numbers

Television? Print Media? (newspaper, town magazines, etc.?)

Internet?

One of our patients - their name? _____

A Friend - What is their name? _____

A Relative - What is their name? _____

How are they related? _____

Your Primary Care Physician

Physician's Name? _____

Another Physician - Name? _____

Other Health Care Service
Name? _____

Other? _____