CONFIDENTIAL PATIENT INFORMATION
Foot Clinic of the High Plains PLLC
2100 FM 2590 Ste 200
Canyon, TX 79015

Patient Information

Patient Name: _____ Date of Birth (Month/Day/Year): _____

Address: _____ Sex (M/F): _____ Marital Status (S/M/W): _____

Address: _____ City: _____ State: _____ Zip: _____

Cell/ Home Phone: _____ Work Phone: _____

Family Physician: _____ Pharmacy: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Foot or Ankle Problem(s)

What problem(s) do you have today? _____

_____

How long? _____ Any treatments? _____ By who? _____

Is this Workman's Compensation? Yes No (If YES, answer questions 1 to 6).

1. Date of Accident: _____ 2. Employer's Name: _____ 3. Contact Person: _____

4. Address: _____ 5. Phone: _____

6. Other information as needed: _____

Insurance Information (<u>or provide us a valid insurance card for copying</u>)

Primary Ins. Co: _____ Insured Name (if different): _____

Insured ID #: _____ Group #: _____

Secondary Ins. Co: _____ Insured Name (if different): _____

Insured ID #: _____ Group #: _____

If patient is <u>below 18 Years of Age</u>, please provide the information of the responsible adult:

Name: _____ Relation: _____ Phone: _____

Address if different: _____

_____

Who referred you to our office?

_____

Please read and sign

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance, and any other health plan to Foot Clinic of the High Plains PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. I understand that I am responsible for payment of charge regardless of having insurance.

Signature: _____ Date: _____

Patient Name: _____

List all medications you are taking (or provide us a list)

_____

_____

_____

_____

Allergies to Medications, Foods, or Supplies? _____

_____

Do you smoke? Yes No If yes, how many packs per day/week: _____

Do you drink alcohol? Yes No If yes, how many drinks per day/week: _____

Are you pregnant (females only)? Yes No If yes, how many months: _____

Medical History

	Yes	No		Yes	No
Diabetes	___	___	High Blood Pressure	___	___
Circulation problem	___	___	Heart (heart attack, CHF)	___	___
Heart murmur, prolapse	___	___	Strokes	___	___
Arthritis	___	___	Gout	___	___
Stomach ulcer / reflux	___	___	Kidney (stones, dialysis)	___	___
Cancer, tumor	___	___	Skin problems, Scarring tendency	___	___
Anemia, bleeding tendency	___	___	Thyroid	___	___
Asthma	___	___	Lung (pneumonia, TB, COPD)	___	___
Seasonal allergies (hay fever)	___	___	Recent weight loss	___	___
Vision, cataracts, glaucoma	___	___	Hearing	___	___
Liver disease, gall bladder	___	___	Pancreas	___	___
Psychiatric problem	___	___	Headache	___	___
Venereal disease	___	___	HIV positive	___	___

Other medical problems: _____

_____

_____

_____

Any Surgeries: _____

_____

_____

Immediate family (grandparents, parents, siblings) medical history

Diabetes___ High blood pressure___ Stroke___ Heart problem___ Cancer___ Kidney disease___

Please Read and Sign

I hereby authorize the doctor(s) of Foot Clinic of the High Plains PLLC and/or assistant(s) to administer treatments deemed necessary in the diagnosis of patient's feet and ankles condition(s) pending discussion of options prior to any procedures.

Signature: _____ Date: _____

Print Patient Name

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES (HIPAA)

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.

$25 LATE FEE

We reserve the right to charge a $25 late fee to any patient who does not pay their bills within 30 days.

$45 NO-SHOW FEE

We reserve the right to charge a $45 fee to any patient who does not show for their scheduled appointment and does not notify us prior to the missed appointment.

NO-SHOW CANCELLATION

We reserve the right to cancel the patient's future appointments if the patient does not show or missed their scheduled appointment 2 (two) times in a row.

COLLECTION AGENCY SURCHARGES

If the patient account is sent for unpaid balances to the Collection Agency, the patient or the guarantor will be responsible for the Collection Agency Surcharges.

Signature of Patient / Legal Representative

Date

Print Name of Legal Representative

Relationship to Patient
(Mother/Father/Guardian/Etc.)