Podiatric Medical Partners PA Of Texas

Dr. William Arrington **Dr. Justin Wade** **Dr. Raymond Delpak**

PATIENT INFORMATION **DATE: __/__/__**

Name: Last_____ First_____Mi_____

Address_____ City_____ State_____ Zip_____

Sex M □ F □ Date of Birth____/____/_____ Age_____ SSN_____-_____-_____ Martial Status_____

Spouses Name _____ Spouse Employer_____

Home Phone_____ Cell phone_____ E-mail address _____

Referred By_____ Name of Family Physician _____ Date Last Seen_____

Pharmacy: _____ **Address** _____ **Phone**_____

EMERGENCY CONTACT INFORMATION

Name: Last_____ First_____ Relationship_____

Home Phone_____ Cell Phone_____

PATIENT EMPLOYER INFORMATION

Employer Name_____ Employer Phone_____

Address_____ City_____ State_____ Zip_____

POLICY HOLDER (GUARANTOR) INFORMATION

Name: Last_____ First _____ Date of Birth_____/_____/_____

Address_____ City_____ State_____ Zip_____

Phone_____ SSN_____-_____-_____ Relationship_____

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to pay directly to Dr. Arrington/Dr. Wade/Dr. Delpak the benefits and amount due and otherwise payable to me for their services, as described on the customary charges for those services. I acknowledge and understand that I am responsible for all of the charges for all services rendered to me or any member of my immediate family.Although I have requested the doctor to bill my insurance company in the case of surgery, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

MEDICARE

I hereby authorize my insurance company to pay directly to Dr. Arrington/Dr. Wade/Dr. Delpak the benefits and amounts due and otherwise payable to me for their services as described, but not to exceed the reasonable customary charges for those services. I understand that I am financially responsible for all remaining charges incurred, whether or not covered by said insurance.

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize Dr. Arrington/Dr. Wade/Dr. Delpak to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with any claims.

SIGNED_____ **DATE**_____

PATIENT MEDICAL HISTORY NAME:

Please circle any of the following conditions that you have or had:

Acne	Cataracts	Gout	Muscular Dystrophy
Anemia	Charcot foot	Heart Attack	Pulmonay Fibrosis
Ankle Swelling	Chemical Dependency	Heart Disease	Raynaud's
Anxiety	Chest Pain	Hepatitis A B C D E	Rheumatoid Arthritis
Arthritis	Circulatory Disorders	Hernia	Seizures
Artificial joint	COPD	High Blood Pressure	Shortness of Breath
replacement	CRPS/RSD	High Cholesterol	Squamous Cell Carcinoma
Asthma	Depression	Hyperthyroid	Stroke
Autoimmune dz	Diabetes	Hypothyroid	Tuberculosis
(HIV/AIDS)	Epilespy	Kidney Disease	Warts
Basal Cell Carcinoma	Fibromyalgia	Liver Disease	Other:
Bleeding Disorders	GI Bleeding	Malignant Melanoma	
Cancer_____	GI reflux/GERD	Mitral Valve Prolapse	

ARE YOU DIABETIC? YES____ NO____ IF YES, LAST GLUCOSE READING_____ A1c_____

PAST SURGICAL HISTORY - please list procedure & date

FAMILY MEDICAL HISTORY

Mother Alive? Yes____ No____ Past/Med Hx_____

Father Alive? Yes____ No____ Past/Med Hx_____

# of Brothers _____ PMH_____

# of Sisters _____ PMH_____

SOCIAL HISTORY - please circle one

Single. Married (___years).Widowed.Separated.Divorced. # of Healthy Children____ # of Deceased Children _____

Live with: Spouse. Family.Nursing Home.Assisted Living.Alone. Other_____

Tobacco Use: Smoker. Smokes ____Packs A Day.Smokeless Tobacco.Non-Smoker. Quit ____ Years Ago. Smoked ____ years.

Illicit Drug use.

Exercise includes: None. Walking Every Day.Walking Occasionally.Jogging.Aerobic Activity ___ Times Per Week.Treadmill.Weight Lifting. Other_____

Caffeine: YES____ NO____ Alcohol: YES____ NO____ If Yes, Daily or Occasionally.

Do you follow any special diet: YES____ NO____ If Yes, Why_____

Sleep Habits: Unremarkable. Patient has: Trouble Falling Asleep, Trouble Staying Asleep, Frequent Nighttime Urination, Daytime Drowsiness, Nightmares, and Restless Legs.

Height____ft _____in.Weight_____lbs. Shoe Size_____

Current Medications and Doses (If Known) Pharmacy_____

1_____	4_____	7_____
2_____	5_____	8_____
3_____	6_____	9_____

Allergic To (Circle): Penicillin, Sulfa Drugs, Aspirin, Codeine, Iodine, Tape, Cortisone, Local Anesthesia, General Anesthesia, Other_____

VASCULAR/NEROPATHY WORKSHEET_-please circle your answer

1. Do you experience pain in your legs/feet when walking? YES/NO
   - If so, where does it hurt when you walk? THIGHS/KNEES/CALVES/FEET
2. Is the pain in your legs/feet relieved by rest? YES/NO
3. Do cuts in your arms/legs or hands/feet take a long time to heal? YES/NO
4. Have you noticed that less hair grows below your knees than above them? YES/NO
5. Do you have or have you had ulcers on your feet? YES/NO
6. Have you noticed that your feet feel cold even when the temperature is warm? YES/NO
7. Do you suffer from numbness, tingling or burning in your legs or arms? YES/NO
   - If so, where? ARMS/HANDS/BUTTOCKS/LEGS/FEET

PODIATRIC MEDICAL PARTNERS OF TEXAS, P.A. - NOTICE OF PRIVACY PRACTICES

WILLIAM C. ARRINGTON, D.P.M. AND ASSOCIATES ARE COMMITTED TO PROTECTING THE PRIVACY AND SECURITY OF INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION AND OTHER PROTECTED HEALTH INFORMATION OF A CONFIDENTIAL NATURE FOR THIS MEDICAL PRACTICE AS SET FORTH IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTACILY ACT ("HIPPA").

I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS "NOTICE OF PRIVACY PRACTICES".

PATIENT SIGNATURE_____ **DATE**_____

CONSENT FOR RELEASE OF INFORMATION & MEDICAL RECORDS

Date: ____/_____/_____

Patients Name: _____

SSN: _____-_____-_____

I hereby give my permission for:

_____

Hospital/Physician/Insurance company

Address:

_____

Phone:_____ Fax:_____

TO RELEASE OR DISCLOSE TO:

Dr. William Arrington/Dr. Justin Wade/Dr. Raymond Delpak @ Beltline/Wylie/Forney/Rowlett Foot & Ankle
1601 N. Beltline Rd. Suite A Mesquite, TX 75149 (Main office)
Ph: 972-288-7441 Fax: 1-855-948-7006

The following information:

_____

For period beginning:_____ and ending:_____.
This information will be used for:_____. I authorize this information to be release. This consent is subject to revocation at any time by me in writing.

Signature of patient/parent (if minor):_____ DATE: _____