7575 San Felipe St., Suite 301
Houston, TX 77063
Office: 713.974.4511 | Fax: 713.974.4501

Today's Date_________________________ ☐ Male ☐ Female

Last Name__________________________ First Name_____________________________

Mailing Address____

City___________________________ State________________ Zip ____________

Primary Phone #_____________________Secondary Phone #___________________________

Email Address_______________________________ SSN ______________________________

Birthdate__________________

Age___________ Height ____________ Weight _______________ Shoe Size ______________

Emergency Contact _______________________ Contact #_____________________________

Pharmacy Name____________________________ Pharmacy Phone #_____________________

Pharmacy Address____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD (S) TO THE RECEPTIONIST)

Primary Insurance__________________ Name of Policy Holder __________________________

Policy # _____________________________ Group # ___________________________________

Relationship to Patient________________ Policy Holder's Date of Birth____________________

Secondary Insurance_________________ Name of Policy Holder__________________________

Policy # _____________________________ Group # ___________________________________

Relationship to Patient_________________ Policy Holder's Date of Birth___________________

REFERRAL INFORMATION HOW DID YOU FIND OUT ABOUT US?

☐ Insurance Company ☐ Doctor ___________________________________

☐ Website ☐ Family Member/ Friend _______________________

GENERAL

Family Physician_____________________________ Phone Number_________________________

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SOCIAL HISTORY Occupation____

Smoking Status □ Never smoker □ Former Smoker: Year Quit _________

□ Current Every Day Smoker: ___________ packs per day

Smokeless Tobacco Use □Yes □No

Alcohol Use □ None □ Former Drinker □ Occasional □ Frequent

Marital Status □ Single □ Married □ Divorced □ Widowed

Exercise □ Doesn't Exercise □ 1-2 days/week □ 3-4-days/week □ 5-7 days/week

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HISTORY OF PRESENT COMPLAINT (**INSURANCE REQUIRES** ALL PARTS TO BE FILLED OUT)

Please explain foot/ankle problems, what part of foot/ ankle:

____

____

□Left □Right □Both

Quality □No Pain □Acute Pain □Chronic □Constant □Dull Ache
□Feels Heavy □Improving □Intermittent □Numbness □Sharp
□Stabbing □Stable □Throbbing □Tingling □Worsening

Severity □Mild □Moderate □Severe
□1-Mild □2 □3 □4 □ 5 □ 6 □ 7 □8 □9 □10-Severe

Duration _______X Days _________ X Weeks __________ X Months ___________ X Years

Timing □Continuous □In the morning □Day time □Night time □Intermittent

Context Occurs □At Rest □At Work □When Standing □While Walking □With Activity □With Exercise
□Other _____________________

Modifying Factors

Relieved □Stopping Activity □When Cold Applied □When Heat Applied
□With Activity □With Anti-Inflammatories □When Lying Down
□With Pain Medication □With Rest □Other_____________

Exacerbated □With Activity □When Exercising □With Standing
□While Walking □Other ______________________

Associated Signs and Symptoms □Fever □Itching □Redness □Swelling
□Weakness □Pain □Other ____________________

Previous Treatment____

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MEDICAL HISTORY SELECT ALL THAT APPLY

□No major illnesses or other prior medical conditions
□Alcohol Dependency
□Anemia
□Arthritis_________________
□Artificial Joints__________
□Asthma
□Bleeding Disorders/Blood Clots
□Cancer__________________
□Cataracts/ Lens Replacement
□Chemical Dependency
□Chemo/ Radiation Treatment
□Current Pregnancy
□Dementia
□Diabetes Type 1
□Diabetes Type 2
□Dialysis
□Disc Herniation
□Drop Foot
□Endocrine/ Hypothyroidism
□Eye, Glaucoma
□GI- reflux/GERD
□Gout
□Heart Arrhythmias (irregular heartbeat)
□Heart Attack
□Heart Disease
□Hearing Loss
□High Blood Pressure
□High Cholesterol
□Implants _______________
□Inflammatory
□Kidney Failure
□Kidney Stones
□Kyphosis/Lordosis (abnormal spine)
□Liver Disease/Hepatitis
□Menopause
□Mental Illness
□Migraine Headaches
□Neurological_____________
□Neuropathy, Numbness
□Osteopenia/Osteoporosis (decreased bone mass)
□Paralysis
□Prostate
□Rheumatoid Arthritis
□Seasonal Allergies
□Sciatica
□Scoliosis (spine curved side to side)
□Short Limb
□Sinusitis
□Spinal Cord Injuries
□Spinal Disc Disease
□Stroke/ TIA/ CVA
□Tremors
□Ulcer- stomach/esophagus
□Urinary Incontinence
□Other___________________
□Other___________________
□Other __________________

____

SURGICAL HISTORY: PLEASE LIST ALL SURGERIES AND YEAR

☐No prior surgeries performed

____
____
____
____
____

FAMILY HISTORY SELECT ALL THAT APPLY AND RELATIONSHIP

☐Unknown family history
☐Not Known-Adopted
☐Alive and Well
☐Alcoholism___________________________
☐Anemia______________________________
☐Anxiety______________________________
☐Arthritis______________________________
☐Cancer_______________________________
☐Cataracts_____________________________
☐Diabetes 1____________________________
☐Diabetes 2____________________________
☐DVT (blood clot in leg)/ PE (blood clot in lungs)__________________________________
☐Gout__________________________________
☐Heart Attack___________________________
☐Hyperlipidemia_________________________
☐Hypertension__________________________
☐Kidney Disease_________________________
☐Neuropathy____________________________
☐Scoliosis______________________________
☐Stroke________________________________

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ALLERGIES (MEDICATIONS/TOPICAL ALLERGIES) PLEASE EXPLAIN ALLERGIC REACTION BELOW

____

____

MEDICATIONS YOU ARE TAKING please list all medications along with dose and reason why you are taking, including OTC medications, vitamins, and herbal supplements

Medication	Reason	Medication	Reason

REVIEW OF SYSTEMS PLEASE CIRCLE WHICH ONE (S) IF YES AFTER PRINTING

Constitutional: Do you have any fever, chills, headache, general tiredness, or weakness?
☐ Yes ☐No
Eyes: Do you have any blurred vision, double vision, blind spots, glaucoma, or eye problems?
☐ Yes ☐No
ENT: Do you have any chronic or persistent ear, sinus, or throat infections or problems?
☐ Yes ☐No
Cardiovascular: Do you have any chest pain/angina, high blood pressure, or heart murmurs?
☐ Yes ☐No
Pulmonary: Do you have a persistent cough, wheezing, shortness of breath, or pneumonia?
☐ Yes ☐No
Gastrointestinal: Do you have any chronic nausea, vomiting, indigestion, heartburn, or stomach pains?
☐ Yes ☐No
Musculoskeletal: Do you have any history of back, neck, or joint pain or injury?
☐ Yes ☐No
Integumentary: Do you have any skin rashes, persistent itching, or other skin problems?
☐ Yes ☐No
Neurological: Do you have any history of tremors, dizzy spells, numbness or tingling?
☐ Yes ☐No
Psychological: Do you have any history of depression, anxiety attacks, or suicidal thoughts?
☐ Yes ☐No
Endocrine: Do you have any history of excessive thirst, weight loss/gain, or too hot/too cold?
☐ Yes ☐No
Hematological: Do you have any swollen glands, excessive bleeding, or blood clots?
☐ Yes ☐No

____

SIGNATURE ON FILE- PERMISSION TO TREAT

I request that payments of authorized benefits be made on my behalf for any services furnished me by Houston Family Foot & Ankle, PLLC. I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any co-insurance, co-pays or deductibles and non-covered services that may be required. I give permission to Houston Family Foot & Ankle, PLLC to examine, photograph, administer and perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

Patient Signature_______________________________________Date________________________

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HIPAA AUTHORIZATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that the Practice cannot share your protected health information (PHI) without your permission, except in certain situations. For example, your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. By signing this form, you are giving us permission to share your PHI as you indicate below.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether I sign this authorization or not. I further understand that I may inspect and copy any information disclosed pursuant to this authorization, and that I will receive a copy of this form upon signing it if I request it.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected.

I understand that this authorization is voluntary and may be revoked at any time. The request to revoke this authorization must be received by the Practice in writing. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

Patient Name (Please Print): ______________________________________

□ I authorize the release of selected medical information, as outlined below:

List the name of the individual to receive information: ______________________________________

Relationship to Patient: □ Spouse □ Child □Other:________________________

Information to be disclosed (Please check all that apply):

☐ Medical Records ☐ Imaging ☐ Financial ☐ Billing/Insurance

Purpose for Disclosure: **At the request of the individual**

□ I do not authorize information to be released to anyone.

Patient Signature: ______________________________________ Date: __________________________

This authorization will remain in effect until terminated by the patient in writing.