HADFIELD
FOOT AND ANKLE
YOUR NEXT STEP FORWARD

Patient Name: _____

D.O.B.: _____**SSN:** _____

_____ **Married** _____**Single** _____ **Divorced** _____ **Widowed** **Sex:** _____**M**_____**F**

Address: _____

City: _____**State:** _____ **Zip Code:** _____

Home# _____ **Work#** _____

Cell# _____**Email:** _____

What is your preferred method of contact? _____ **Phone** _____**Text** _____ **Email** _____ **Mail**

Are you Employed? _____**Yes** _____**No** **Occupation:** _____

Emergency Contact: _____ **Phone:** _____

Relationship to Patient: _____

Primary Care Physician: _____

PCP Phone: _____**Last Date Seen:** _____

Primary Insurance Name: _____

Member ID: _____ **Group:** _____

Policy Holders Name: _____

Policy Holders SSN: _____

Policy Holders D.O.B.: _____

Patient's relationship to Policy Holder: _____

Effective Date: _____**Termination Date:** _____

Hadfield Foot and Ankle
1505 Harroun Avenue, Suite H
McKinney, TX 75069
P: 469-247-1900 F: 888-365-3177

Patient's Name: _____D.O.B._____

Seondary Insurance Name: _____

Member ID: _____ Group: _____

Policy Holders Name: _____

Policy Holders SSN: _____

Policy Holders D.O.B.: _____

Patient's relationship to Policy Holder: _____

Effective Date: _____Termination Date: _____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Robert Hadfield, DPM and Hadfield Foot and Ankle to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Robert Hadfield, DMP and Hadfield Foot and Ankle on any unpaid services filed on my behalf. **I understand that I am responsible for payment to Robert Hadfield, DPM and Hadfield Foot and Ankle for charges for the above patient regardless of my insurance coverage**. I also understand that Robert Hadfield, DPM and Hadfield Foot and Ankle are not responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Robert Hadfield, DPM permission to diagnose and administer treatment for my foot and/or ankle condition.

Patient's Signatrue: _____Date: ___

Parent/Guardian's Signature: _____Date: _____

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Patient's Name: _____D.O.B._____

Chief complaint (What brings you to our office today?):

_____
_____
_____
_____

General Medical History (Please mark any conditions that you have/had:

- ☐ Acid Reflux
- ☐ Alcohol/Drug Addiction
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder/Blood Clots
- ☐ Bowel Problems
- ☐ Broken Bones
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Collagen Vascular Disease
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Gall Bladder Disease
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease/Attacks
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Joint/Back Pain
- ☐ Kidney Disease/Stones
- ☐ Lung Disease
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures/Epilepsy
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Thyroid Disease - hypo/hyper
- ☐ Tuberculosis
- ☐ Ulcers/Acid Reflux
- ☐ Other_____

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Patient's Name: _____D.O.B._____

Smoking History:		Never smoked				
		Currently Smoke		Cigarettes/Day for		Years
		Previously smoked		Cigarettes/Day for		Years

Alcohol History:		Never use				
		Occasionally		drinks/day		drinks/week
		Socially		drinks/day		drinks/week

Do you currently use recreational drugs?:		Yes - What drugs?
		No

Family History: (List any family medical problems)

Date	**Immunizations:**
	Tetanus-Diphtheria Booster
	Pneumoccocal Vaccine
	Varicella Vaccine
	Flu Shot
	Hepatitis B Vaccine
	Measles-Mumps-Rubella Vaccine

Height: _____ Weight: _____Shoe Size: _____

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Patient's Name: _____D.O.B._____

REVIEW OF SYSTEMS:

Constitutional:		Change in appetite		Weight loss
		Change in height		Weight gain
		Difficulty sleeping		Night sweats
		Fatigue		Other
		Fever		

Eyes:		Double vision		Spots before eyes
		Blurred vision		Vision Changes
		Glasses/contacts		Other

Ears, Nose, Throat:		Congestion		Ringing in ears
		Difficulty swallowing		Runny nose
		Earaches/Ear infections		Seasonal allergies
		Hearing problems		Sinus problems
		Mouth sores		Sore throat
		Neck stiffness/pain		Other
		Nose bleeds/bleeding gums		

Cardiovascular		Chest pain or pressure		Varicose veins
		Leg pain		Difficulty breathing when lying flat
		Leg swelling		Difficulty breathing with exertion
		Rapid or irregular heart rate		Other

Respiratory:		Chronic Cough		Wheezing
		Coughing up blood		Difficulty breathing when lying flat
		Painful breathing		Difficulty breathing with exertion
		Shortness of Breath		Other

Gastrointestinal:		Abdominal Pain		Hemorrhoids
		Acid reflux/heartburn		Incontinence
		Black tarry stools		Indigestion
		Bloody stools		Jaudice
		Constipation		Nausea/Vomiting
		Diarrhea		Other

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Patient's Name: _____D.O.B._____

REVIEW OF SYSTEMS:

Genitourinary:		Blood in urine		Pain with urination
		Frequently urination		Discoloration of urine
		Urinary incontinence		Other
		Frequent urinary tract infections		

Musculoskeletal:		Back pain		Muscle weakness
		Joint pain		Joint swelling
		Joint stiffness		Redness or swelling of joints
		Muscle pain/cramps		Other

Skin:		Discoloration		Moles
		Difficulty healing		Open wounds/sores
		Dry skin		Rash
		Easy bruising		Other
		Itching		

Neurologic:		Burning		Headaches
		Tingling		Seizures
		Numbness		Tremors
		Dizziness		Other

Psychiatric:		Anxiety		
		Depression		
		Other		

Endocrine:		Abnormal hair growth		
		Abnormal thirst		
		Hair loss		
		Heat/cold intolerance		
		Other		

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Patient's Name: _____ D.O.B._____

Past Surgical History:

Date	Surgery

Medications (Please include any vitamins, herbs, supplements or non-prescription drugs:

Drug Name	Dose

Allergies:

Drug/Food/Other	Reaction

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone# _____