PATIENT INFORMATION

Age____________ DOB________/________/__________ (____) Male (____) Female

Full Name ____

Address ____

City/State/Zip ____

Cell Phone ______________________ Home Phone______________________

Which you prefer to be called on first: ( ) Cell ( ) Home

Email ____

Whom may we release medical information to: ______________________________

Employer ______________________Occupation______________________

Emergency Contact ______________Phone (_______) ____________Relationship:____________

Pharmacy ______________________ Address ______________ City______________

MARTIAL STATUS:	**PRIMARY LANGUAGE:**	**ETHNICITY:**	**RACE:**
☐ Married	☐ English	☐ NOT Hispanic or Latino	☐ White
☐ Single	☐ Spanish	☐ Hispanic or Latino	☐ Native Hawaiian or Pacific Islander
☐ Widowed	☐ Other	☐ Decline	☐ Asian
☐ Divorced	____________		☐ Black or African American
			☐ American Indian or Alaskan Native
			☐ Decline

HOW CAN WE CONTACT YOU? (check ALL that apply)

☐ Phone	☐ Mail	☐ Email	☐ Text Message

OKAY TO LEAVE MESSAGE WITH:

☐ Self Only	☐ Patient and/or spouse	☐ Anyone answering phone

HOW DID YOU HEAR ABOUT US?

☐ Friend	☐ Google	☐ Doctor Referral	☐ Yelp	☐ Insurance	☐ Internet	☐ Other______________

INSURANCE INFORMATION:

PRIMARY Insurance Name & ID No	**ID #:**
Policy Holder Name & Birthday	**DOB: / /**
Policy Holder Employer	

SECONDARY Ins. Name & ID No	**ID #:**
Policy Holder Name & Birthday	**DOB: / /**

Notification of Changes

If/when any of the above information, (i.e. name, phone number, insurance,) changes, I will provide the updated information promptly.

X____**DATE**______________________

Patient's Signature or Parent/ Legal Guardian

Trinity Foot Center Lisa J. Brandy D.P.M. | 1801 N. Hampton Road Ste. 340 Desoto, TX 75115 * Phone: 972-293-9650 * Fax: 972-291-2533

MEDICAL HISTORY

PATIENT NAME: ____

Family physician:______________________________ Phone#____________________ Last seen:__________

DIABETIC PATIENTS: Doctor who treats your Diabetes: ______________________________ Last seen: _________

State in your own words your medical reason(s) for coming into our office:

____

____

Please list ALL MEDICATIONS that you currently use:

____

____

For **ALL** patients:

What is your shoe size? _________
Are you a current smoker? Yes No
Has the patient received a flu vaccination for the current season? Yes No
If **No**, what is the reason?: ( ) Patient allergy ( ) Patient declined ( ) Vaccine unavailable

Patients 65 or older:

Do you have a living will or someone to make decisions on your behalf? Yes No
Have you had a pneumonia vaccination? Yes No
Have you fallen in the past 12 months? Yes No

MOTHER has/had any of following diseases: **Circle ALL that apply:** Diabetes High Blood Pressure Heart Trouble Kidney Disease None

FATHER has/had any of following diseases: **Circle ALL that apply:** Diabetes High Blood Pressure Heart Trouble Kidney Disease None

Have YOU ever HAD or HAVE any of the following?

YES	NO	ALCOHOLISM	YES	NO	GOUT
YES	NO	ALLERGIES/HAYFEVER	YES	NO	HEART DISEASE
YES	NO	ANEMIA	YES	NO	HIGH BLOOD PRESSURE
YES	NO	ARTHRITIS	YES	NO	HIV/AIDS
YES	NO	ASTHMA	YES	NO	KIDNEY DISEASE
YES	NO	CANCER	YES	NO	LUNG/COPD
YES	NO	DIABETES	YES	NO	STOMACH ULCER/GERD
YES	NO	DRUG ABUSE	YES	NO	STROKE
YES	NO	EPLIEPSY/SEIZURE	YES	NO	THYROID
YES	NO	EYE (CATARACT/GLAUCOMA)	YES	NO	TROUBLE WITH HEARING
YES	NO	ANXIETY/DEPRESSION			

Are you ALLERGIC to or have you ever reacted to any of the following?

YES	NO	ASPRIN	YES	NO	LIDOCAINE (LOCAL ANESTHESIA)
YES	NO	BAND-AIDS/ TAPE	YES	NO	SULFA DRUGS
YES	NO	LATEX	YES	NO	PENICILLIN
YES	NO	STEROIDS	**OTHER:** ____________		

FOR WOMEN ONLY: ARE YOU PREGNANT? ______________IF SO HOW MANY MONTHS? _________

X______________________________________ ____________________
Patient's Signature or Parent/ Legal Guardian Date

PATIENT NAME:____

Authorization for Insurance to Pay

I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Trinity Foot Center, PC, the office of Lisa J. Brandy, DPM. I hereby agree to promptly pay for any service(s) provided to me not covered by my insurance policy. I agree to pay all co-payments, deductibles, coinsurance, and products sold through Trinity Foot Center, PC.
I authorize the above named provider to release to the Social Security Administration or its intermediaries any information needed for the claim or related medical claim. I further permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for the charges not covered by my insurance program.

Non-Covered Services

It is important to understand that some of the services provided to you may not be covered under your current insurance plan. Therefore, it is important that you check with your insurance company to verify your benefits. You will be responsible for full payment of any services not covered by your insurance at the time of your visit.

Surgery

Some minor surgical procedures are performed in our office. Most insurance carriers put these in the category of "surgery", meaning that the procedure may be applied to a surgical deductible or coinsurance. Therefore, you may be billed for an amount over and above the usual visit co-payment at your visit. If the procedure is not covered by your insurance, we will require 100% payment at the time of the surgery.

Appointments

It is our goal to provide services to you in the most comfortable and timely manner possible. In order to achieve this, we ask that you be on time for your appointments. We realize your time is valuable and we endeavor to keep on schedule, while providing each patient with personalized care. However, emergencies do occur, and may cause delays in our schedule. We will try to keep you informed of these delays should they arise. **If you must cancel an appointment, we ask that you kindly notify us at least 24 hours in advance. There is a $25 fee for each no show occurrence.**

Prescription Refills

Prescription refills or change requests will be handled within 24 hours of the receipt of the request during regular office hours. Please contact your pharmacy so that a written request can be faxed to our office. No prescription refill or change requests will be handled after regular office hours or on the weekend.

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.

Thank you for choosing us for your foot care needs. If you have any questions regarding these policies, please notify a member of our business office during regular hours. We will do our best to ensure your understanding of our policies so that we may concentrate on you and your care. I acknowledge that I have read and understand the contents of the financial and office policies for Trinity Foot Center, PC.

X____Date________________________
Patient's Signature or Parent/ Legal Guardian