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

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_____

Family physician:_____Phone#_____ Last seen:_____

DIABETIC PATIENTS: Doctor who treats your Diabetes: _____ Last seen: _____

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	**Member ID #:**
Policy Holder Name & Birthday	**DOB: / /**
Policy Holder Employer	

SECONDARY Ins. Name	**Member 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

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MEDICAL HISTORY

PATIENT NAME: _____

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

_____

_____

Shoe Size: _____	**Are you a current smoker? Yes No**

MEDICATIONS- Please list all medications that you currently use:

_____

_____

_____

ALLERGIES- 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:** _____		

YOUR Past Medical History: Have **YOU** ever **HAD or HAVE** any of the following?
CIRCLE ALL THAT APPLY

Eyes :	Cataract	**Respiratory:**	Asthma
	Glaucoma		COPD
ENTM :	Trouble Hearing	**GI:**	GERD
Integumentary:	Eczema		Stomach ulcers
	Odor	**CVS:**	Stroke
	Sweaty feet		Kidney disease
Allergies:	Seasonal Allergies		Heart Disease
Musculoskeletal :	Gout		High Blood Pressure
	Arthritis	**Endocrine:**	Diabetes
Neurological:	Cramping (legs or feet)		Thyroid disorder
	Numbness (legs or feet)		Anemia
	Tingling (legs or feet)	**Psychiatry:**	Depressed
	Burning (legs or feet)		Anxiety
	Seizure	**Immunology:**	Cancer
Social:	Alcoholism		HIV/AIDS
	Drug Abuse		
		(___) NONE OF THE ABOVE	

FAMILY Past Medical History: Circle **ALL** that apply

Father:	Diabetes	Kidney Disease	Hypertension	Cancer	None	Unknown
Mother:	Diabetes	Kidney Disease	Hypertension	Cancer	None	Unknown

FOR WOMEN ONLY: ARE YOU PREGNANT? _____ IF SO HOW MANY MONTHS? _____

X_____ _____

Patient's Signature or Parent/ Legal Guardian Date

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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.

Products and DME Supplies

All over-the-counter products purchased are non-refundable. All durable medical equipment (DME) such as ankle/foot braces, shoes, and walking boots, etc. are non-refundable once dispensed.

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