



3030 Matlock Rd Ste 102 Arlington Tx 76015 / 17110 Dallas Pkwy Ste 180 Dallas, Tx 75248

NEW PATIENT REGISTRATION

Patient Information:

Full Name (first, middle, last) : _____

Age: _____ Date of Birth: ____/____/____ SS#: _____

Gender: Male / Female Marital Status: __ Single __ Married __ Divorced __ Widowed __ Separated

Home Address: _____

Phone Number: Mobile: _____ Home: _____

Email: _____

Primary Care Doctor: _____ Last Date of Visit: _____

Emergency Contact: Name: _____ Relationship: _____

Phone : _____

Insurance Information:

Subscriber Name: _____ Relationship to patient: _____

Primary Insurance: _____

Group #: _____ ID _____

Secondary Insurance: _____

Group #: _____ ID _____

Workers compensation Insurance:

Date of injury: ____/____/____ Employer: _____

Insurance Carrier: _____ Claim Number: _____

Claims Adjuster (if known): _____



MEDICAL HISTORY

Patient Name: _____

Height: _____ Weight: _____ Shoe Size: _____

What is the reason for your visit today?

How long have you had symptoms ? _____

What Past Treatments have you had? _____

Did you see another doctor for treatment? _____ If so, who _____

If injury, what was the Date of Injury: _____

Did the injury occur at work? Yes / No

Describe how the injury occurred: _____

Past Medical History: Please check any of the following conditions you have had or now have.

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Foot Wounds |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Peptic Ulcers | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Colitis or Crohns | <input type="checkbox"/> Type 1 Diabetes | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Type 2 Diabetes | _____ |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Kidney problems |
| _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Dialysis? Yes/No |
| <input type="checkbox"/> Arthritis Type _____ | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart problems : _____ | <input type="checkbox"/> Seizures | <input type="checkbox"/> Staph infections |
| | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer Type: _____ |
| | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Neuropathy |
| | | <input type="checkbox"/> Depression |
| | | <input type="checkbox"/> Sleep apnea |

Other: _____

Allergies : (Medications, Latex, Food, Etc) : Please List Any

Current Medications: Please List Name and Dosage

Pharmacy Name: _____ **Phone :** _____

Past Surgical History: Please list All Surgeries

Family Medical History:

High Blood Pressure Heart Disease Diabetes Arthritis Gout Stroke
 Other: _____

Social History:

Alcohol Use: Yes/ No How long and how much? _____

Tobacco Use : Yes/No What type, how long and how much? _____

Recreational Drug use: Yes/ No What type, how long and how much? _____

Exercise or Sports activities: Yes/ No Type and frequency: _____

REVIEW OF SYSTEMS: (Circle if any symptoms)

CONSTITUTIONAL/GENERAL : Weight Gain Weight Loss Chills Fever Weakness/Fatigue Other:

EYES: None Blurred Vision Glasses Contacts Eye Pain Redness Vision Change Cataracts
Glaucoma Other: _____

EARS, NOSE, THROAT: None Nose Bleed Ear Ache or Infection Ringing in Ear Hoarseness Loss of
Hearing Other: _____

CARDIOVASCLAR : None Chest Pain Swelling in Legs Shortness of Breath Palpitations
Other: _____

RESPIRATORY: None Shortness of Breath Wheezing/Asthma Frequent Cough Other: _____

GASTROINTESTINAL : None Heartburn Vomiting Nausea Abdominal Pain Acid Reflux Other:

MUSCULOSKELETAL: None Arthritis Stiffness Muscle Aches Swelling of Joints Instability Other:

SKIN: None Rash Itching Redness Abnormal Scars Keloids Psoriasis Ulcers/Sores Other:

NEUROLOGICAL: None Headaches Numbness, Tingling, Loss of Sensation in ANY Body Part
Dizziness Poor Balance Fainting Spells Seizures Other: _____

PSYCHIATRIC: None Depression Nervousness Anxiety Mood Swing Other: _____

ENDOCRINE: None Excessive Thirst or Hunger Hot/Cold Intolerance Hot Flashes Other: _____

HEMATOLOGICAL: None Easy Bruising Easy Bleeding Varicose Veins Blood Clots

Signature of Patient/ Legal Guardian : _____

Date: ____/____/____



CONFIDENTIAL OFFICE MEDICAL RECORD

Name _____ Date _____

Chief Complaint

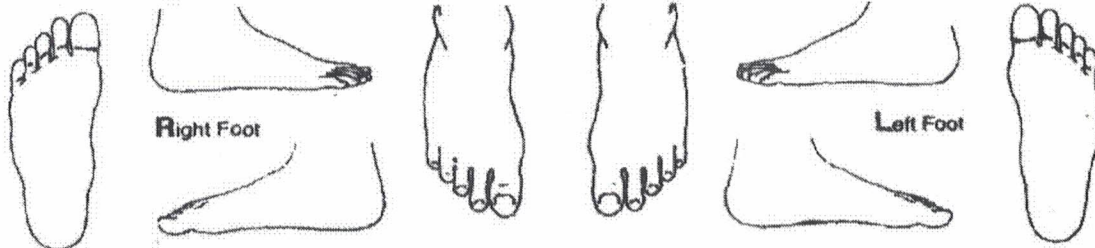
Patient Height _____ Weight _____ Shoe Size _____

What is your main foot problem today? _____

Do you have any other foot problems that need attention? _____

History of Present Illness

Mark on the diagram below the areas where each problem is located.



When did your main problem begin? _____ []Days []Weeks []Months []Years ago.

Is the pain: []Burning, []Throbbing, []Sharp, []Dull, []Aching, []Tingling, []Numbness, []Itching, []Other _____

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10
(No Pain) PLEASE CIRCLE (Extreme pain)

Is the pain worse after rest or after activity? []Rest []Activity

What causes the problem or makes it worse? _____

Was it caused by an injury? []No []Yes (if yes, explain) _____

What previous treatments have been used?:
Self: _____
Professional: _____

Patient/Guardian Signature _____ Date: ____/____/____

Financial Policy

Thank you for choosing AllCare Foot & Ankle Center, P.A for your podiatric needs. It is important that you read this financial policy agreement before receiving treatment. We will also bill your insurance carrier as a courtesy to you.

To be treated by AllCare Foot & Ankle Center, P.A. you must understand, agree to and initial the provisions set forth below:

I understand that if I need to reschedule my appointment, I must call to reschedule at least 24 hours before the said appointment. I understand that a \$25 fee will be applied to all office visit consultation appointments not cancelled within a 24 hour period.

I understand that my healthcare policy is an agreement between myself and the insurance company. If the insurance company has not paid my bill in full within 60 days of treatment, I agree to contact them to facilitate payment.

I understand that insurance copayments, co-insurance and deductibles are due prior to receiving treatment.

I agree that any payments sent directly to me from insurance should be used to directly pay my Provider. I agree to immediately forward to Provider all payments, explanation of benefits and correspondence sent directly to me from all Third Party Payers related to the care rendered by the Provider.

I understand that all treatment charges are my responsibility whether the insurance company pays or not. I understand that not all services are a covered benefit and that I am financially responsible for and agree to pay all charges not paid by my insurance or Third Party Payer within 60 days from time of service. This includes, but is not limited to, copayments, deductibles and co-insurance.

I understand that I am financially responsible for any increased co-pays, deductibles and non-covered services provided on an out-of-network basis.

I agree to fully cooperate with Providers to assist in their efforts to get claims paid on my behalf. It is my sole responsibility to verify the status of my healthcare benefits directly from my Third Party Payers and to determine what portion of the care rendered by the Provider will be covered by my Third Party Payers. I agree to pay any and all charges not paid for by my Third Party Payer within 60 days of receiving said care.

I agree to promptly notify AllCare Foot & Ankle Center, P.A of any changes in my health insurance plan and/or coverage including changes to my address and/or phone number. I understand that my failure to do so will make me fully responsible for the entire bill as this is not the responsibility of the Provider. In consideration of the services furnished to me, I hereby agree to pay any balance due within thirty (30) days from presentation of my bill and that Providers are not required to honor any limiting notations I make on a payment.

As a courtesy to our patients, we will obtain any pre-authorization and/or pre-certification required prior to services performed; *HOWEVER*, I understand that it is my responsibility to ensure these pre- authorization and/or pre-certifications are obtained. This is not the responsibility of my Provider. I also acknowledge that no guarantees have been made by any employee of the Provider, physician or other party about my treatment including whether it will be paid for by any Third Party Payers and/or whether Provider is in or out of my network with my Third Party Payers.

ASSIGNMENT AND RELEASE: I authorize payment to be made directly to AllCare Foot & Ankle Center, P.A and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my claims. If legal action becomes necessary, I agree to pay all collection fees.

Responsible Party (Please Print)

Date

Responsible Party Signature _____