WEATHERFORD PODIATRY CLINICS, P.A.

PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (___) ___-_____ YES NO

ALTERNATE PHONE #: (___) ___-_____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

PHARMACY: _____ LOCATION: _____ PHONE #: (___) ___-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

_____ YES NAME(S) _____

_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

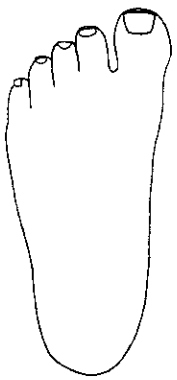
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

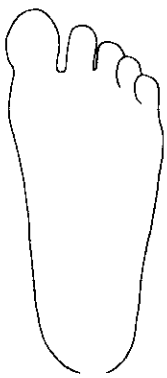
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

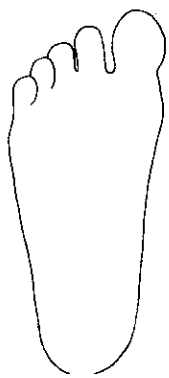


BOTTOM OF FOOT

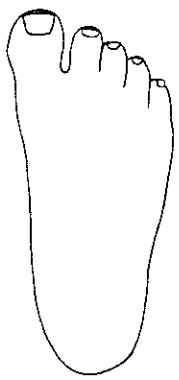
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT



BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT

INSIDE OF FOOT

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE

Weatherford Podiatry Clinics, P.A.

Dr. Waymon Lewis, Jr., D.P.M.

224 Santa Fe Dr
Suite # 300
Weatherford, TX 76086

817.341.3901

OFFICE FINANCIAL POLICY

All appointments require a 24-hour notice of cancellation or you will be charged a fee of $40. This fee MUST be paid before future appointments can be made.

All charges for services rendered to a patient are due at the time of service. This is to include any copays or coinsurance amounts and deductible amounts.

It is the patient's responsibility to see that the bill is paid in full. We want to emphasize that, as your Podiatric Medical Care Provider, our relationship is with you and NOT WITH YOUR INSURANCE COMPANY.

As a courtesy to you, we will file your insurance claim, however, if Dr. Lewis is not contracted with your particular insurance company, you will be given the correct information to file the claim yourself.

Medicare and other insurances may cover x-rays, injections, and some other types of foot care; however, routine foot care such as trimming of the toenails, calluses, or corns may not be otherwise indicated by your insurance provider.

I have read and understand this policy.

_____ _____

Signature/Patient or Guardian Date

_____

Patient Name Printed

Weatherford Podiatry Clinic, P.A.

Waymon E. Lewis, Jr., D.P.M.

Patient Financial Policy

Weatherford Podiatry is dedicated to providig the best posssible care and service to you. We regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or manager.

All appointsments made require a 24 hour notice of cancellation or a charge of $40 will be added to your account. This fee MUST be paid before any future appointments are made.

As an outpatient, you are responsible for all authorizations/referrals needed to seek treatment in this office. All copays and deductible amounts are due at the time of service. We will accept cash, debit/credit cards, checks, or money orders as payment.

Your insurance policy is a contract between you and your insurance company. Your claim will be filed for you with your signature to pay the doctor directly. If your insurance does not pay the practice within the legal specified time period, you will be responsible for payment.

This office does accept assignment with insurers and health plans. This means that we agree to accept the amount allowed by your insurance company as our charge. You may have a percentage of the allowed amount to pay depending on how your policy reads.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization as required by your health plan. You will be responsible for payment of the complete c harge. We will attempt to verify specialized services, however, you remain responsible for charges for any services rendered.

You must inform the office of all insurance changes and authorizations or referral arrangements prior to treatment. In the event this office is not informed, you may be responsible for any charges that are denied.

There may be certain procedures which will require prepayment. You will be informed in advance if your procedure is one of them. In the event that prepayment is required, payment will be due one week prior to the procedure.

Past due accounts are suject to collection proceedings. All fees, including but not limited to colllections fees, attorney fees, and court fees shall become your responsibility. This will be in addition to any balance due to this office.

There is a minimum fee of $25 for any additional forms such as FMLA, leave of absence of employers, short-term/long-term disability, etc. This fee is dependent on the size of the document and could be up to $50.

There is a fee of $25 for returned checks.

_____ _____

Patient Signature/Responsible Party Date

Weatherford Podiatry Clinics, P.A.
Waymon E. Lewis, Jr., DPM
224 Santa Fe, Suite 300
Weatherford, Texas 76086

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the **Health Insurance Portability and Accountability Act of 1996** (HIPPA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

* conduct, plan, and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and Indirectly
* obtain payment from third party payers
* conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received you ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is to be used or disclosed to carry out treatment, payment, or healthcare options. I also understand that you are not required to request restrictions, but if you do agree, then you are bound to abide by such restrictions.

PATIENT NAME: _____

Relationship to patient: _____

Signature: _____ Date:_____

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:_____ Initials: _____

Reason: _____

Adapted April 14, 2003 (HIPPA Privacy)

WEATHERFORD PODIATRY CLINICS, PA

DR. WAYMON LEWIS

224 SANTA FE, STE 300

WEATHERFORD, TX 76086

817-341-3901

RELEASE OF MEDICAL INFORMATION

PATIENT NAME:_____

PATIENT SIGNATURE:_____

DATE: _____

DOB:_____