

ADVANCED FOOTCARE

TO OUR NEW PATIENTS:

I would personally like to thank you for choosing Advanced Footcare and welcome you to our practice. We are located at 1635 N. Lee Trevino Ste. C, El Paso, Texas 79936. After 16 years of being in practice here in El Paso, I find that one of the most challenging things today, are insurance companies. The insurance companies in today's world have different processes as to what needs to be authorized and verified and that is one of the most common delays that we have in our office.

In order to assist us in seeing you in a timely manner prior to your appointment, please fill out the following patient packet. Please bring this packet with you at the time of your appointment along with an identification card, your insurance card, and all medications that you take. You may bring a list of medications including the name, dosage, frequency, and the reason you take the medication.

Some insurance policies may require a referral from your primary care physician or an authorization in order for you to be seen. It is your responsibility to provide this information to our office. *If you are not able to provide this information your insurance unfortunately will not allow our office to be able to see you until the correct referrals and authorizations are provided.*

Please be sure to bring along with you on the day of your appointment any recent x-rays, tests, scans, reports, or any other pertinent information or items that may assist us in your treatment. Please complete and sign all forms, including the HIPPA form, as this is a federal requirement to protect you for all disclosure of your health information.

Thank you for choosing Advanced Footcare and we welcome you to our facility.

Dr. Gabriel Lazar
Dr. Vivianne Nguyen

Financial Agreement

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Advanced Footcare, allowing the use of my medical records as needed for payment. This authorization is hereby considered valid until revoked by me in writing. I understand that I am financially responsible for all charges made to my account. I will be responsible for all co-payment, co-insurance amounts, non-covered supplies/services, and yearly deductibles. Payment for these services, are expected at the time services are rendered. **I understand there is a \$25.00 fee for any returned check to the office. If I fail to cancel my appointment without providing a 24hour notice/no show I will be responsible for a \$25.00 service charge.**

Signature

Date

HIPPA FORM

I, _____, understand that as a part of my healthcare, Advanced Footcare originates and maintains paper and/or electronic records describing my healthcare history, symptoms, test results, examination, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment,
- Means of communication among the many healthcare professionals who contribute to my care,
- Source of information for applying my diagnosis and surgical information to my bill,
- Means by which a third party payer can verify that services billed were actually provided and,
- Tool for routine healthcare operations such as: Assessing quality and reviewing the competence of healthcare professionals.

I understand and have received a notice of information practices, that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Advanced Footcare is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I further understand that Advanced Footcare reserves the right to change their notice and practices, and prior to implementation, in accordance with section 164.520 of the code of federal regulations. Should Advanced Footcare change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organizations treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or e-mail.

I fully understand and: ACCEPT DECLINE the terms of this consent.

PATIENT'S SIGNATURE

DATE

RECEIVED BY: _____ ON _____

PATIENT REFUSED CONSENT /TREATMENT REFUSED: _____

ADVANCED FOOTCARE

(FILL OUT ALL FORMS COMPLETELY. DO NOT LEAVE ANY BLANKS; IT WILL DELAY YOU BEING SEEN BY THE PHYSICIAN. PLEASE PRINT)

TODAY'S DATE: _____
PATIENT'S NAME: _____ **D.O.B.:** ___/___/___
AGE: ___ **GENDER:** Male Female **SS#:** ___ - ___ - ___
MARITAL STATUS: Married Single Divorce Other
ADDRESS: _____
CITY: _____ **ST:** _____ **ZIP CODE:** _____
HOME#:(___) ___ - ___ **CELL#:**(___) ___ - ___ **WORK#:**(___) ___ - ___
EMPLOYER: _____ **OCCUPATION:** _____
WORK/OFFICE ADDRESS: _____ **PHONE#:** (___) ___ - ___

RESPONSIBLE PARTY: Same As Above
NAME: _____ **D.O.B.:** ___/___/___ **GENDER:** Male Female
RELATIONSHIP: _____ **SS#:** ___ - ___ - ___
OCCUPATION: _____ **EMPLOYER:** _____
ADDRESS: _____ **PHONE#:** (___) ___ - ___
CITY: _____ **ST:** _____ **ZIP CODE:** _____
HOME#:(___) ___ - ___ **CELL#:**(___) ___ - ___ **WORK#:**(___) ___ - ___

EMERGENCY CONTACT:
NAME: _____ Relationship: _____
Phone#: (___) ___ - ___

HOW WERE YOU REFERRED TO OUR OFFICE?
 Friend/Family Insurance Website Magazine Other: _____
 Physician: **DR.:** _____ Phone#: (___) ___ - ___

HEALTH INSURANCE INFORMATION:
PRIMARY INS. COMPANY NAME: _____
POLICY HOLDER'S NAME: _____ **DOB#:** ___/___/___
GENDER: Male Female **SS#:** ___ - ___ - ___
POLICY#: _____ **GROUP#:** _____
EMPLOYER: _____ **RELATIONSHIP TO PT:** _____

SECONDARY INS. NAME: _____
POLICY HOLDER'S NAME: _____ **DOB#:** ___/___/___
GENDER: Male Female **SS#:** ___ - ___ - ___
POLICY#: _____ **GROUP#:** _____
EMPLOYER: _____ **RELATIONSHIP TO PT:** _____

Medical History Questionnaire

Date: ___/___/___

Name: _____ DOB: ___/___/___

Did your problem begin following:

Work Injury? Motor Vehicle Accident? Daily Regimen? Nothing?

Is your complaint on:

Right foot Left foot Both feet

Reason for visit?

Ankle pain Bunion Flat feet Heel pain Plantar wart Corns/calluses Sweaty feet
 Swelling Ingrown toenail Athlete's feet Cramps Discolored toenails
 Ulcers Numbness Other: _____

How long have you had this problem and/or condition? _____

Please rate your pain on a scale of 1 to 10 (10 being the most painful):

At rest: 1 2 3 4 5 6 7 8 9 10 **At its Worst:** 1 2 3 4 5 6 7 8 9 10

Type of pain or sensation? Constant Occasional Dull Aching Stabbing

Throbbing Sharp Numbness Burning Itching Swelling Bruising

Other: _____

Does anything make your symptoms feel *better*? Yes No

If yes explain: _____

Does anything make your symptoms feel *worse*? Yes No

If yes explain: _____

Have you seen another Physician for this problem? Yes No

Name of Dr. _____ Phone # (____) ____ - _____

Last visit: _____ Number of times seen: _____

What treatment was received? Nothing Physical Therapy Injections

Medications Other: _____

Have you had any of the following tests/studies? Yes No

Tests	Date (Month / Year)	Facility
X-Rays		
MRI Scan		
Nerve Studies		
Blood Tests		
Other:		

Physician's Initials: _____ Date: ___/___/___

Date: ___/___/___

Name: _____ DOB: ____/____/____

FAMILY PHYSICIAN:

Dr. _____ Phone#: (____) _____ - _____

Last visit: _____

Cardiologist: Dr. _____ Phone#: (____) _____ - _____

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from: None

<input type="checkbox"/>	AIDS / HIV	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Neuropathy
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Parkinson's
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	Artificial valves	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Reflux Disease (GERD)
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hepatitis Type: _____	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Seizure disorder
<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	Cholesterol High / Low	<input type="checkbox"/>	Sports Injury
<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Cancer Type: _____ Active / Remission	<input type="checkbox"/>	Kidney Failure / Disease / Problem / Transplant	<input type="checkbox"/>	Thyroid Hyper / Hypo
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Circulation	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Ulcer Disease (GI)
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Varicose Veins

Other Problem Not Listed: _____

Comments Regarding Medical History: _____

If Diabetic: For how long: _____ Do you take: Pills / Insulin / Both

Are you in Dialysis? Yes / No What Physician treats you? _____

Are you on a blood thinner? Yes / No Name: _____ How Long? _____

Have you had an organ transplant? Yes / No Type: _____

Woman Only: Are you pregnant? Yes / No If Yes, how many months? _____

Are you currently breastfeeding? Yes / No

Past Surgical History:

Please list all surgeries you have had in the past: None

Type of Surgery	Date	Surgeon / Place

Physician's Initials: _____ Date: ____/____/____

Name: _____ DOB: ____/____/____

Pacemaker		Stent	Where:	
Other:				

ALLERGIES:

No known drug allergies

Are you allergic to:	Yes	No	Reaction
Codeine			
Penicillin			
Sulfa			
Iodine / Betadine			
Neosporin			
Local Anesthetic			
Latex Gloves			
Motrin / Advil / Ibuprofen			
Aspirin			
Eggs			
Other:			

SOCIAL HISTORY:

Special Diet: Yes No

Any Restrictions? _____

Tobacco Use: Yes No

Type: _____ Duration: _____ Quit Date: _____

Alcohol Use: Yes No

Frequency: _____

Recreational Drug Use: Yes No

Type and Frequency: _____

FAMILY HISTORY

None

Family History:	Yes	No	Who?
Diabetes			
Cancer			
High Blood Pressure			
Blood Clots			
Rheumatoid Arthritis			
Osteoporosis			
Other:			

