Steven Stanton, D.P.M.
**Family Foot Care**
...Your Feet's Best Friend
7087 Highway 6 North, Houston, Texas 77095

# PODIATRIC REGISTRATION AND HISTORY

## PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate _____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

## PHONE NUMBERS

Home_____ Work_____ Ext _____

Best time and place to reach you_____

Can we leave a message at this number? ☐ Yes ☐ No

**IN CASE OF EMERGENCY, CONTACT**

Name_____ Relationship_____

Home Phone_____ Work Phone_____

## INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____

Birthdate _____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coninsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

## PODIATRIC HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before? ☐ Yes ☐ No

If yes, please list.

Name_____

Last Visit_____

Is there any personal or family history of diabetes? ☐ Yes ☐ No

Your occupation_____

Cigarette/Tobacco use_____

Years smoked_____

Athletic activities in which you participate (please list and indicate frequency)

_____

_____

_____

Please indicate which foot problems you now have or have had in the past.

| | |
|---|---|
| Ankle Pain | ☐ Yes ☐ No |
| Athlete's Foot | ☐ Yes ☐ No |
| Bunions | ☐ Yes ☐ No |
| Corns and Calluses | ☐ Yes ☐ No |
| Cramps or Numbness in Feet or Legs | ☐ Yes ☐ No |
| Flat Feet | ☐ Yes ☐ No |
| Foot or Leg Cramps | ☐ Yes ☐ No |
| Heel Pain | ☐ Yes ☐ No |
| Ingrown Toenails | ☐ Yes ☐ No |
| Plantar Warts | ☐ Yes ☐ No |
| Swelling in Ankles or Feet | ☐ Yes ☐ No |
| Tired Feet | ☐ Yes ☐ No |

## MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Rash | ☐ Yes | ☐ No |
| Allergies to Anesthetics | ☐ Yes | ☐ No | Eye Problems | ☐ Yes | ☐ No | Respiratory Disease | ☐ Yes | ☐ No |
| Allergies to Medicine or Drugs | ☐ Yes | ☐ No | Fainting | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Foot or Leg Cramps | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| Angina | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Sinus Problems | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Special Diet | ☐ Yes | ☐ No |
| Artificial Heart Valves or Joints | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Hemophilia | ☐ Yes | ☐ No | Swelling in Ankles, Feet | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No | Hepatitis or Jaundice | ☐ Yes | ☐ No | Swollen Neck Glands | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Tired Feet | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Kidney Problems | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Low Blood Pressure | ☐ Yes | ☐ No | Varicose Veins | ☐ Yes | ☐ No |
| Chronic Diarrhea | ☐ Yes | ☐ No | Nervous Problems | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No | Phlebitis | ☐ Yes | ☐ No | Weight Loss, unexplained | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No | | | |
| Ear Problems | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No | | | |

Surgeries you have had_____

_____

_____

_____

Hospitalization other than for the surgeries listed_____

_____

_____

_____

Family physician_____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past tow years? ☐ Yes ☐ No

I yes, please explain _____

_____

_____

_____

## MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins_____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

## ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant
☐ Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

## CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Patient's Signature _____ Date _____

**Written Acknowledgement of Receipt of Cy-Fair Family Foot Care Joint Notice of Privacy Practices**

By signing below, you acknowledge receiving the Cy-Fair Family Foot Care Joint Notice of Privacy Practices (Notice). The Notice explains how Cy-Fair Family Foot care may use and disclose your protected health information for treatment, payment and healthcare operations purposes. Protected health information means your personal health information found in your medical and billing records.

Cy-Fair Family Foot Care reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice will be available at our office and on our website at www.houstonpodiatry.com. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, each time you register for healthcare services at our office, we will have available for you, at your request, a copy of the current Notice in effect.

Your signature below only acknowledges that you have received the Notice.

If you have any questions about the Notice, please contact the Cy-Fair Family Foot Care Privacy Officer. Contact information is located in the Notice.

Printed Name of Patient _____

Patient's Date of Birth _____

Name of Patient's Representative _____

Relationship of Patient's Representative _____

Signature of Patient or Patient's Representative _____

Date _____