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BRAZOS VALLEY FOOT CARE, PA

PATIENT INFORMATION SHEET

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____ **GEN:** ☐ Jr. ☐ Sr.

PREFERRED NAME: _____ **BIRTHDATE:** _____ **AGE:** _____

GENDER: ☐ Male ☐ Female SSN: _____-_____-_____ TX DL #: _____

MAILING ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PH #: _____ **WORK PH #:** _____ **CELL PH #:** _____

E-MAIL ADDRESS: _____

ETHNICITY: Are you Hispanic or Latino? ☐ Yes ☐ No

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other

RACE: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

EMERGENCY CONTACT: _____ PHONE #: _____ RELATION: _____

LEGAL REPRESENTATIVE/RESPONSIBLE PARTY: Who is responsible for the bill, if other than patient?

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ RELATION TO PATIENT: _____

HOW WERE YOU REFEERED TO THE OFFICE?

☐ BVFC Website ☐ Friend or Relative ☐ Insurance ☐ Phone Book ☐ Other _____
☐ Established Patient ☐ Facebook/Social Media ☐ Internet ☐ Physician

CONSENT FOR TREATMENT

I hereby give permission to Brazos Valley Foot Care to examine and/or perform diagnostic tests, and treat my condition medically, surgically or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, why may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV. BVFC is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier or welfare agency that may be providing financial acceptance for hospital care. I understand that although I have medical insurance, **I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.**

SIGNATURE: _____ DATE: _____
Signature of Patient or Legal Guardian

Acknowledgement of Practice's Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP). I have read and/or was given the opportunity to read if I so chose and understood the Notice and agree to its terms. ***Notice of Privacy Practice is available at the front window upon request***

Signature: _____

FINANCIAL POLICY FOR BRAZOS VALLEY FOOT CARE, PA

Financial Policy for Brazos Valley Foot Care, PA is available at the front window upon request

Signature: _____

FINANCIALLY RESPONSIBLE PARTY (If not the patient)

PRINT Name: _____ Signature: _____ Relationship: _____

Medical Record Release

I give authorization to Brazos Valley Foot Care, PA to disclose or release my complete medical and billing records for medical reasons, insurance purposes, and employment purposes.

Signature: _____

PATIENT HISTORY

Reason for Visit: _____

Are you having any foot pain? ☐ Yes ☐ No Please rate pain on scale of **1-10**: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

When did your discomfort begin? _____

Describe pain/discomfort: ☐ Burning ☐ Numbness ☐ Sharp ☐ Other _____

Have you previously been treated for this problem? ☐ Yes ☐ No If yes, list type of treatment: _____

Height: _____ Weight: _____ Shoe Size: _____ Shoe Width: _____

Preferred Pharmacy: _____ City: _____

Primary Care Physician: _____ City/State**:** _____

Are you **Diabetic**? ☐ Yes ☐ No Diabetic Physician: _____Date Last Seen: _____
If yes, is your **HbA1c** level: ☐ > 9 ☐ < 7 ☐ Between 7-9 ☐ Not Performed

List all current **Medications & Vitamins:** (Include dosage, frequency & route of administration) ☐ *No Current Medications*

_____

_____

_____

List any **Allergies** to medications**:**

_____

_____

Past Medical History: ☐ *No Past Medical History*

☐ Arthritis	☐ Bleeding Disorder	☐ Cancer	☐ Circulatory Problems	☐ Diabetes
☐ Gout	☐ Heart Disease	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/Aids	☐ Kidney Disease	☐ Neurological Disorder	☐ Other: _____	

Surgical History:

_____

_____

Family History: ☐ *No Known Family History*

☐ Bleeding Disorder (Mother/Father)	☐ Cancer (Mother/Father)	☐ Diabetes (Mother/Father)	☐ Heart Disease (Mother/Father)
☐ Hypertension (Mother/Father)	☐ Kidney Disease (Mother/Father)	☐ Stroke (Mother/Father)	☐ Other: _____

Social History: (Please check the below conditions that apply to your social history)

☐ Tobacco Use If yes: ☐ Light/Social ☐ Heavy/Everyday ☐ Former Use
☐ Alcohol Use
☐ Drug Use (Recreational or IV)

If you are 65 years or older, *please answer the below questions below:*

Have you fallen in the past 12 months? ☐ Yes ☐ No If yes, how many falls? _____ Injured due to fall? ☐ Yes ☐ No

Have you experienced any changes, issues and/or complications with vision? ☐ Yes ☐ No

Have you experienced any problems with Heart Rate and/or Heart Rhythm? ☐ Yes ☐ No

Have you experienced any problems with Incontinence? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please check the conditions that you are currently experiencing and/or have previously experienced:

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Constitutional:

☐ Fever ☐ Chills ☐ Sweats ☐ Weight Loss ☐ None Apply

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Eyes:

WEARING OF: ☐ Contacts ☐ Cataracts ☐ Eye Glasses ☐ None Apply HAVE/HAVE HAD: ☐ Cataracts ☐ Double Vision

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ENTM:

☐ Difficulty Swallowing ☐ Neck Pain ☐ Sore Throat ☐ Nose Bleeds
☐ Dizziness ☐ Ringing of Ears ☐ Dentures ☐ None Apply

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Cardiovascular:

☐ Chest Pain ☐ Heart Attack ☐ Congestive Heart Failure ☐ Heart Murmur
☐ Palpitations ☐ Circulatory Disease ☐ Swelling in Legs/Ankles ☐ Leg Pain w/ Exercise
☐ Cardiovascular Surgery ☐ Hypertension ☐ Pace Maker ☐ None Apply

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Hematologic:

☐ Bleeding Abnormalities ☐ Anemia ☐ Lump in Groin or Armpit ☐ Lymphoma ☐ Swollen Glands ☐ None Apply

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Respiratory:

☐ Shortness of Breath ☐ Emphysema ☐ Cough ☐ Bronchitis ☐ Difficulty Breathing
☐ Wheezing ☐ Asthma ☐ Pulmonary Disease ☐ TB Exposure/Treatment ☐ Pneumonia ☐ None Apply

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Gastrointestinal:

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Stomach Ulcers
☐ Decrease in Appetite ☐ Blood in Stool ☐ Hepatitis ☐ Acid Reflux ☐ None Apply

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Endocrine:

☐ Often Thirsty ☐ Often Urinating ☐ Kidney Disease ☐ Pancreatitis
☐ Diabetes Mellitus ☐ Prostate Problems ☐ Thyroid Disorder ☐ None Apply

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Musculoskeletal:

☐ Tendonitis ☐ Bursitis ☐ Broken Bones ☐ Arthralgia
☐ Weakness in Limbs ☐ Feeling Weak ☐ Joint Pain ☐ None Apply

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Neurologic:

☐ Migraines ☐ Seizures ☐ Stroke ☐ Ataxia (Loss of Balance) ☐ Aphasia (Loss of Speech)
☐ Confusion ☐ Fainting ☐ Neuropathy (Loss of Sensation) ☐ Speech Difficulties ☐ None Apply

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Integumentary:

☐ Rash ☐ Skin Ulcers ☐ Lesions ☐ Cracking of Skin ☐ Sensitivity to Sun ☐ Change in Skin Color
☐ Growth on Skin ☐ Recurrent Infections ☐ Eczema ☐ Keloid ☐ Hair Loss ☐ None Apply

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Psychological:

☐ Nervousness ☐ Tension ☐ Depression ☐ Anxiety ☐ None Apply

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: _____ Date: _____

Print Form