TEXAS FOOT & ANKLE
SURGICAL ASSOCIATES, PLLC

Office of Dr. Charles White, DPM, FACFAS
Tel: 830-491-9211 Fax: 833-471-2992

Patient Information

Name: _____ Date of Birth: _____

Address: _____City: _____State: _____

Phone #: _____ Home / Cell Email: _____

Employer: _____ Title: _____

Emergency Contact: _____ Phone#_____ Relation: _____

Primary Insurance Co: _____

Policy #/ ID: _____ Group #: _____

Subscriber (if not patient): _____Relationship to Subscriber _____

Secondary Insurance Co: _____

Policy #/ ID: _____ Group #: _____

Subscriber (if not patient): _____Relationship to Subscriber _____

Primary Care Provider _____ Date last seen _____

Referring Provider / Clinic / Hospital _____

Preferred Pharmacy _____ Location _____

How did you hear about us? Referral / Insurance / Family / Friend / Internet / Ad / _____

Reason for Visit: _____

** Please provide your ID & Insurance Cards on check in.* **Please inform us of any changes to your information.*

Patient Signature _____ Date_____

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PATIENT MEDICAL HISTORY

Allergies

❑ NONE ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Metals ❑ Iodine/Shellfish/Contrast ❑ Latex ❑ Morphine ❑ Penicillin

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Other:		

SOCIAL HISTORY

□ **Yes** □ **No -** Do you drink alcohol? □ Daily □ Weekly □ Infrequently □ Recovering
□ **Yes** □ **No -** Do you smoke? □ Smoke (___ packs per day) □ Chew
□ **Yes** □ **No -** Do you drink caffeine? □ Daily □ Weekly □ Infrequently

Surgical History: Please list any Surgeries.

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ Allergies
❑ Anemia
❑ Arthritis conditions
❑ Asthma
❑ Arterial fibrillation
❑ Bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ Cancer
❑ Cardiac arrest
❑ Celiac disease
❑ Chest pain
❑ Congestive heart failure
❑ COPD
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Ear nose or throat disease
❑ Fibromyalgia
❑ Gerd
❑ Heart disease
❑ Hyperinsulinemia
❑ Hyperlipidemia
❑ Hypertension
❑ Hives
❑ Hypothyroidism
❑ Infection problems
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney problems
❑ Menopause
❑ Migraines/headaches
❑ Neuropathy
❑ Onychomycosis
❑ Organ injury
❑ Osteoporosis
❑ Pulmonary Disease
❑ Vascular Disease
❑ Seizure disorders
❑ Sinus conditions
❑ Stroke
❑ Problems with Anesthesia

OTHER:

Medications: List any medications you are currently taking (please include over the counter medications):

MEDICATION	DOSAGE/FREQUENCY	MEDICATION	DOSAGE/FREQUENCY

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POLICIES AND ACKNOWLEDGEMENTS

Assignment of Benefits and release of medical information to insurance: I hereby assign to Texas Foot and Ankle Surgical Associates, PLLC, any insurance or other third-party benefits available for health care services provided to me. I understand that Texas Foot and Ankle Surgical Associates, PLLC, has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Texas Foot and Ankle Surgical Associates, PLLC, I agree to forward to Texas Foot and Ankle Surgical Associates, PLLC, all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I understand and agree that my medical information may be released to my insurance company for insurance purposes. This waiver also authorizes the release of copies of my medical records to healthcare providers and organizations who are involved in my continued care. I understand I have the right to obtain copies of my medical records.

No Show and Late Cancellation Policy: Kindly give us 24 hours' notice of rescheduled or canceled appointments. Multiple no show appointments may be subject to dismissal from the practice.

Payment Policy: All services rendered are the financial responsibility of the patient at the time services are rendered. **All copays, co-insurance and or deductibles are due at the time services are rendered.** The patient is responsible for payment regardless of insurance status or coverage. I understand and agree that I, the patient, am ultimately responsible for the balance on my account for any services rendered and I agree to pay upon demand or as agreed for the related changes of remaining charges following my insurance payment(s). If private pay, I agree to pay for services in full on the date services are rendered. There are payment plan options.

Self-Pay and Cash Discounts: Cash discounts are offered on most services to uninsured patients who pay in full at the time of service or by the "Due Date." We offer Care Credit as well as reasonable payment plans should expenses pose a financial burden.

Non-Payment: Please be aware that if a balance remains unpaid, your account may be turned over to a collection agency after the 90th day past due.

Acknowledgement of Review of "Notice of Privacy Practices": I acknowledge that the practice provided me or offered me a written copy of the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions and am entitled to receive a copy of this notice if requested.

Referrals: Some insurance plans require a referral from a primary care physician to obtain the services of a specialist. These health plans will not pay for services rendered without a referral. It is your responsibility to obtain a referral prior to treatment, otherwise your appointment may be rescheduled or delayed.

Filling Out Forms: There is an up to $25 fee for filling out Disability/FMLA or other forms. Please allow 5 business days.

Authorization of Medical Information to Family Member or Persons: We are committed to protecting our patients' privacy as well as complying with state and federal law. Please list below anyone that you would like to be able to speak to the practice on your behalf. It is the patients' responsibility to notify the practice of any changes to this authorization. **I authorize the practice to speak to:**

Name:_____Relationship:_____Number:_____
Name:_____Relationship:_____Number:_____
Name:_____Relationship:_____Number:_____

I have reviewed the policies above and do hereby agree with the terms and policies.

Patient/Guardian Name _____DOB: _____

Signature _____ Date: _____