Date:___/___/___

Patient Information Sheet

First name:_____Middle Name:_____ Last name: _____

Social Security Number: _____-_____-_____ Date of Birth:_____/_____/_____ Gender:_____

Home Address: Street:_____Apt #:_____
City:_____ State:_____ Zipcode:_____
Home Phone: (_____)-_____-_____ Cell phone: (_____)-_____-_____ Work: (_____)-_____-_____
E-mail:_____ Fax: (_____)-_____-_____

Pharmacy name:_____Phone number:(____)-_____-_____
Address:_____

Insurance Information: *Please fill out so that there are no billing confusions, thank you!*
Primary Insurance:_____
Insured party name:_____DOB:_____
Social security #:_____ID #_____
Group #:_____Effective date:_____
Relationship to patient: (self, spouse, parent)_____

Secondary Insurance:_____
Insured party name:_____DOB:_____
Social security #:_____ID #_____
Group #:_____Effective date:_____
Relationship to patient: (self, spouse, parent)_____

Was this an accident? Yes or No If yes, date of accident/ injury:_____/_____/_____
Location of the accident:_____ Is an attorney involved? Name:_____

Was this a workers comp injury? _____ What body part?_____
Referred by: _____Employer: _____
Work Comp insurance:_____
Claim #:_____Adjuster name & phone #_____

Primary Care Physician:_____Phone #:_____
Date of last visit:_____/_____/_____
Medicare Patients: *In compliance with Medicare guidelines you MUST be current (seen within the last 6 months) with your PCP or endocrinologist.*
Shoe size:_____
Where did you hear about us?_____

Emergency contact:_____Phone number:(____)-_____-_____
Relationship to patient:_____

_____ _____
Patient Signature Date

2911 Medical Arts Street Bldg 17 Austin, TX 78705 P:512-474-6666

Capital Foot & Ankle
Surgeons of Austin

Original Date:

Trinity M. Mereau, DPM **Steven A. Walters, DPM**

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F **DOB:**

Primary care Physician **Date of last seen by PCP:**

Who may we thank for referring you?

REVIEW OF SYSTEMS

Please check if you have recently been experiencing any of the following:

General	☐ Fatigue	☐ Fever/ chills	☐ recent weight change	☐ no symptoms
Skin	☐ Rash	☐ Itching	☐ Lesions/sores/limps	☐ no symptoms
Eyes	☐ Blurred vision	☐ Blindness	☐ Floaters	☐ no symptoms
Ears	☐ Deaf	☐ Decreased hearing	☐ Dizziness	☐ no symptoms
Nose	☐ Loss of smell	☐ Nose bleeds	☐ Sinus problems	☐ no symptoms
Respiratory	☐ shortness of breath	☐ wheezing	☐ coughing	☐ no symptoms
Cardiovascular	☐ chest pain	☐ swelling ankle/ feet	☐ high blood pressure	☐ no symptoms
Neurologic	☐ seizures	☐ numbness	☐ headaches	☐ no symptoms
Gastrointestinal	☐ nausea	☐ vomiting	☐ abdominal pain	☐ no symptoms
Genitourinary	☐ frequent urination	☐ painful urination	☐ incontinence	☐ no symptoms
Hematologic	☐ bleeding	☐ excessive bruising	☐ use of blood thinners	☐ no symptoms
Musculoskeletal	☐ limitation in motion	☐ Weakness	☐ stiffness	☐ no symptoms
Vascular	☐ calf pain	☐ leg cramp	☐ rest pain	☐ no symptoms
Endocrine	☐ excessive thirst	☐ excessive urination	☐ thyroid problems	☐ no symptoms
Psych	☐ anxiety	☐ depression	☐ insomnia	☐ no symptoms

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed:

☐ **Cancer** Location:

☐ **OB/GYN:**

☐ **Skin:** ☐ Scleroderma ☐ Steven Johnson

☐ **Head, Ears, Eyes:** ☐ Cataracts ☐ Macular Degeneration ☐ Retinal Detachment ☐ Blind ☐ Deaf

☐ **Respiratory:** ☐ Asthma ☐ COPD ☐ Pulmonary Embolism ☐ Sleep apnea

☐ **Cardiac problems:** ☐ Congestive Heat Failure ☐ Coronary Artery disease ☐ Blood clot ☐ High cholesterol
☐ Hypertension ☐ Mitral Valve Prolapse ☐ Murmur ☐ Stroke ☐ Heart Attack (when?)

☐ **Gastrointestinal:** ☐ Gastro-esophageal reflux ☐ Hepatitis ☐ IBS ☐ Peptic ulcer

☐ **Urinary:** ☐ Renal failure ☐ Dialysis (what days?)

☐ **Musculoskelatal:** ☐ back pain ☐ Osteoarthritis/ Arthritis ☐ Osteoporosis ☐ Raynaud's

☐ **Neurologic:** ☐ Alzheimer's ☐ Multiple sclerosis ☐ Neuropathy ☐ Parkinson ☐ Seizures

☐ **Psychiatric:** ☐ Alcoholism ☐ Anxiety ☐ Depression ☐ Attention deficit ☐ Drug abuse

☐ **Hematolgic:** ☐ Anemia ☐ Sickle cell

☐ **Endocrine:** ☐ Diabetes ☐ Hyperthyroidism ☐ Hypothyroidism

☐ **Allergy/ Immunology:**

☐ **Infectious Disease:** ☐ AIDS ☐ HIV ☐ Osteomyelitis

☐ **Rheumatolgy:** ☐ Ankylosing spondolitis ☐ Fibromyalgia ☐ Gout ☐ Reiter's ☐ Rheumatoid arthritis

☐ **Trauma:** ☐ Motor vehicle accident ☐ Fractures/ Broken bones: Location?

Please add or explain any other medical condition:

Surgeries/ Hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (bottom left corner pill bottle)

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had	**Name the Drug**	Reaction You Had

SOCIAL

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

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

Exercise

☐ Sedentary (No exercise)

☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)

☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)

☐ Regular vigorous exercise Activity? Mileage? #minutes?

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

How many drinks per week?

Tobacco

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day

☐ # of years ☐ Or year quit

Drugs

Do you currently use recreational or street drugs? ☐ Yes ☐ No

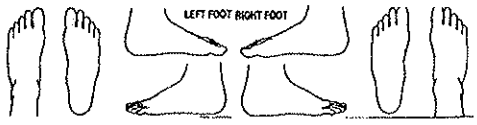
FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Sibling**	☐ M ☐ F	
Mother				☐ M ☐ F	

******Please Mark the location of your foot and ankle pain:**

Date of injury/ problem began_ /__ _/ _

Describe the pain/ Discomfort:



Is the problem work related?

Capital Foot & Ankle
Surgeons of Austin

Financial Policy

Our goal is to provide comprehensive quality care to all of our patients. It is necessary to establish policies to avoid misunderstandings. The following are the policies of the practice.

Insurance coverage: We participate in many insurance plans. We do not file automobile or other third party liability claims (accident policies, litigations, etc.) If you are not insured, payment in full will be collected at each visit. Knowing your insurance benefits is your responsibility. You are responsible for the portion of your charges that are not covered. Please contact your insurance company with any questions about your coverage or claims processing.

Estimated cost: In situations in which your deductible has not been met or you are responsible for a percentage of the cost of your visits, durable medical equipment and surgery then the charges we give you are an estimate and are subject to change based on your insurance. We do our best to be as accurate as possible with the information we are able to obtain from your insurance company. Refunds will be handled upon final services rendered and are handled by the office monthly.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a picture ID (passport, Drivers license, etc) and valid proof of insurance at the time of visit. If you do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. If you fail to provide us with the correct insurance information in a timely manner, you must notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Co-payments & Balances: Co-payment is due at the time you check in. This arrangement is part of your contract with your insurance company. Please note that Capital Foot & Ankle Surgeons of Austin physicians are specialty physicians and higher co-pays may apply. If you cannot pay your co-payment you might need to reschedule your appointment. Unpaid deductibles, co-insurance percentages, and other outstanding balances are also due upon checking in with our front office. If payment is unable to be made in full, financing options are available.

Referrals: We will do our best effort to obtain a referral from your primary care physician if your insurance requires them. However, there are times that this may be difficult and you will be required to obtain the referral yourself. You may be rescheduled until we have obtained the referral in order to comply with the requirements of your insurance.

Work related injuries: You must tell our office if your injury/ condition is work related. We must verify your claim before your appointment. If you work for an employer who is covered under provision of the Texas Workers' Compensation and the claim is found to be fraudulent or non-compensable, you will be fully responsible for all charges.

Non-payment: Statements are due and payable in full upon receipt. In the event that your bank returns payment made by a personal check, a service fee of $25.00 will be billed to your account. If any balance is outstanding, we may refer your account to a collection agency and you may be discharged from the practice. If this office must take action to collect an outstanding balance on your account, you will be responsible for payment of all costs of such collection efforts.

Missed Appointments: We respect your time and strive to see you at your appointment time. Communicating when you are late is greatly appreciated and often times we will then be able to accommodate you on the schedule. If there is no communication with our office prior to your actual appointment time, you will be considered "missed.Capital Foot and Ankle Surgeons of Austin may charge $50 missed appointment fee for missed visits.

Medical Records: There is a $10 charge for chart notes and a $25 charge for records to include xrays due at the time of patient pick up.

I have read and understand the financial policies and agree to abide by all guidelines.

_____
Patient Name

_____ _____
Signature Date

2911 Medical Arts Street Bldg 17 Austin, TX 78705 P:512-474-6666

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights 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 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 have been given the right to review the Notice of Privacy Practices prior to signing this acknowledgement. I understand that *Capital Foot & Ankle Surgeons of Austin* reserves the right to change these policies at any time and I may contact the office for an update copy at any time.

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

_____
Patient Name

_____ _____
Signature Date

2911 Medical Arts Bldg 17 Austin, TX 78705 P:512-474-6666

Capital Foot & Ankle
Surgeons of Austin

Consent to Release Personal Medical Information

I, _____, give my consent to the Staff and Physicians with Capital Foot & Ankle Surgeons of Austin to release any medical information pertaining to me to the following people:

Name (please print)	Relationship	Phone (___)-_____-_____
Name (please print)	Relationship	Phone (___)-_____-_____
Name (please print)	Relationship	Phone (___)-_____-_____
Name (please print)	Relationship	Phone (___)-_____-_____

Please understand that we cannot share information with your family and friends at any time unless they are listed above.

_____
Patient Name

_____ _____
Signature Date