ETFA
EAST TEXAS FOOT ASSOCIATES

DR. MARK E. SOWELL, DPM
DR. MATTHEW DAUGHERTY, DPM

## PATIENT DATA/EMERGENCY NUMBERS

Date:____/_____/_____

STAFF USE

Name:_____ Your Occupation

Acct#_____

Shoe Size_____ Weight_____ Height_____

Reviewed: ☐ NEW ☐ UPDATE

In case of emergenvy, please firts call:

Phone -Day _____

Phone -Evening _____

Friend or Relative not living with you:

Phone -Day _____

Phone -Evening _____

Please provide your preferred Pharmacy:

Street/ City: _____

Phone: _____

## PATIENT MEDICAL HISTORY

Do you have or ever been treated for:

| | | |
|---|---|---|
| ☐ Epilepsy | ☐ Nerve disorder | ☐ Cancer |
| ☐ Depression | ☐ Stomach Ulcer | ☐ Psychiatric Disorder |
| ☐ Glaucoma | ☐ Rheumatic Fever | ☐ Scarlet Fever |
| ☐ Stroke | ☐ Heart Attack | ☐ High Blood Pressure |
| ☐ Trauma | ☐ Phlebitis | ☐ Heart Disease |
| ☐ Diabetes | ☐ Hepatitis | ☐ Liver Disease |
| ☐ Anemia | ☐ Gout | ☐ Kidney Disease |
| ☐ Asthma | ☐ Lung Disease | ☐ None of these |

Additional **NOT LISTED** above:

Are you currently taking any medication ☐ Yes ☐ No

Medication For what reason? How long

**Allergies:** Do you have a history of skin reaction or oher outward reaction or sickness following an injection, oral or topical administration of.

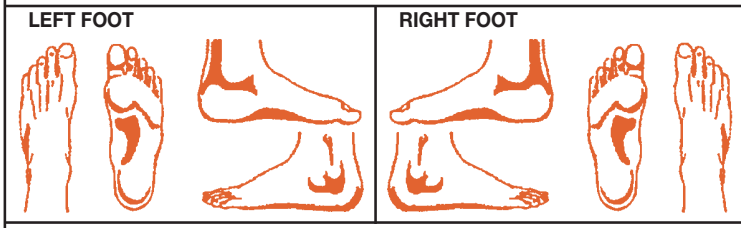
| *(check box that applies)* | *Yes* | *No* | *Don't know* |
|---|---|---|---|
| Penicillin or other antibiotics | ☐ | ☐ | ☐ |
| if yes, what happens: _____ | | | |
| Morphine, Codeine Denerol or other narcotic | ☐ | ☐ | ☐ |
| if yes, what happens: _____ | | | |
| Novocaine or other anesthetics | ☐ | ☐ | ☐ |
| if yes, what happens: _____ | | | |
| Aspirin, Empirin or other pain remedies | ☐ | ☐ | ☐ |
| if yes, what happens: _____ | | | |
| Sulfa drugs | ☐ | ☐ | ☐ |
| if yes, what happens: _____ | | | |
| Adhesive tape | ☐ | ☐ | ☐ |
| if yes, what happens: _____ | | | |
| Shrimp, Iodine or Merthiolate | ☐ | ☐ | ☐ |
| if yes, what happens: _____ | | | |
| Any other medication or treatment | ☐ | ☐ | ☐ |
| if yes, List _____ | | | |

Do you smoke now? ☐ No ☐ Yes Packs/day _____ Years _____

Did you ever smoke? ☐ No ☐ Yes Packs/day _____ Years _____

## PATIENT CURRENT MEDICAL PROBLEMS

Describe up to 2 main problems in greater detail below & mark on the diagram below the areas where you have each problem using numbers 1 to 2 to identify.




1. Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below and it's cause if you know. Please describe associated pain.

My first problem is... ☐ On Left foot ☐ On Right foot ☐ On Both feet

_____ Is this problem work related? ☐ Yes ☐ No

Date of injury:_____ Date of report to employer:_____

My Pain/Discomfort began:_____

It occurs when:_____

Previous medical treatment(s) or home remedies:

2. Please mark the location of your first problem or pain on the diagrams above with a number 2. Describe your problem below and it's cause if you know. Please describe associated pain.

My first problem is... ☐ On Left foot ☐ On Right foot ☐ On Both feet

_____ Is this problem work related? ☐ Yes ☐ No

Date of injury:_____ Date of report to employer:_____

My Pain/Discomfort began:_____

It occurs when:_____

Previous medical treatment(s) or home remedies:

Additional Information: _____

Patient Family Physician Referred by ☐ Yes ☐ No

1400 Raguet St., Nacogdoches, Tx 75961 | 307 W Cottage Road, Carthage, TX 75633 | 900 Ellis Ave, Lufkin,TX 75904
Hurst St Suite B, Center, TX 75935 | 606 W Columbia St, San Augustine, TX 75972
(936) 559-1713

ETFA EAST TEXAS FOOT ASSOCIATES
DR. MARK E. SOWELL, DPM
DR. MATTHEW DAUGHERTY, DPM

# PATIENT INFORMATION

Thank you for choosing sowell podiatry! In order to serve you properly, we need the following information.
**Please print.** All information will be kept confidential.

Date _____ Patient Name _____ Home Phone _____

SS# _____ ☐ Male ☐ Female Birthdate _____

Address _____ City _____ State _____ Zip _____

Circle appropriate status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Patient's or parent/guardian employer _____ Work Phone _____

Bisiness Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone _____

If patient is a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

In case of an emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X _____ _____
Parent or guardian signature Date

## Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Employer _____

Work Phone _____ Is this person currently a patient in our office? ☐ Yes ☐ No

## Insurance Information

Name of insured _____ Relationship _____

Birthdate _____ SS# _____ Work Phone _____

Name of employer _____ Date employed _____

Addresse of employer _____ City _____ State _____ Zip _____

Insurance of employer _____ Group # _____ Deductible amount _____

Do you have additional insurance? ☐ Yes ☐ No If yes. complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ SS# _____ Work Phone _____

Name of employer _____ Date employed _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group# _____ Deductible amount _____

*I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating & administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.*

X _____ Date _____
Signature of patient or parent / guardian if minor Date

1400 Raguet St., Nacogdoches, Tx 75961 | 307 W Cottage Road, Carthage, TX 75633 | 900 Ellis Ave, Lufkin,TX 75904
Hurst St Suite B, Center, TX 75935 | 606 W Columbia St, San Augustine, TX 75972
(936) 559-1713

ETFA EAST TEXAS FOOT ASSOCIATES
DR. MARK E. SOWELL, DPM
DR. MATTHEW DAUGHERTY, DPM

# MODEL PATIENT ACKNOWLEDGMENT OF RECEIPT

## SOWELL PODIATRY NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge receiving a copy of Sowell Podiatry Notice of Privacy Practices, dated _____

Patient Name _____ Patient D.O.B. _____

Patients Social Security # _____

X _____ _____
Signature of patient or personal representative* Date

* If signed by a Personal Representative, the following information must also be included:

Name of Personal Representative _____

Description of the Personal Representative's authority to act on behalf of the patient

_____

_____

_____

_____