EAST TEXAS FOOT ASSOCIATES - NACOGDOCHES • CARTHAGE • LUFKIN • CENTER • SAN AUGUSTINE
(936) 559-1700 • (877) 747-3668 TOLL-FREE

PATIENT INFORMATION

Patient's Last Name	First	Middle Initial

Street Address	City	State	Zip Code	Home Phone

Cell Phone	Date of Birth	▫ Male ▫ Female	Social Security Number	Marital Status ▫ Single ▫ Married ▫ Divorced ▫ Widowed

Patient's Occupation	Patient's Employer	Emergency Contact Name	Emergency Phone Number

Employer Street Address	City	State	Zip Code	Work Phone

What type of Insurance do you have?
▫ Medicare ▫ Medicaid ▫ BC/BS ▫ Aetna ▫ Cash Pay ▫ Other:

Policy Number	Group Number

Is Policy Holder the patient? ▫ Yes ▫ No	If not, Name of Policy Holder?	Date of Birth Policy Holder	Relationship ▫ Spouse ▫ Parent ▫ Other

Policy Holder Social Security Number	▫ Male ▫ Female	Patient Email Address

HOW DID YOU HEAR ABOUT US?

▫ Google ▫ Yahoo ▫ Ins. List
▫ Bing ▫ Facebook ▫ Other

▫ Doctor's Office/Clinic:
▫ Family/Friend:

MEDICAL HISTORY

Family Doctor:	Date Last Seen:	Pharmacy:

Shoe size:	Height:	Weight:	Smoke? ▫ No ▫ Yes: _____ packs/day ▫ Ex-Smoker quit _____ years ago

Vaccines: Flu ▫ No ▫ Yes when? _____ Pneumonia ▫ No ▫ Yes when? _____

Alcohol? ▫ No ▫ Yes: _____ per _____

Family Medical History

▫ Heart Disease MOTHER___ FATHER___
▫ High Blood Pressure MOTHER___ FATHER___
▫ Diabetes MOTHER___ FATHER___
▫ Cancer MOTHER___ FATHER___
▫ Cholesterol MOTHER___ FATHER___

Your Medical History

▫ High Blood Pressure
▫ Heart Disease
▫ Asthma
▫ Bleeding Problems
▫ Kidney Disease
▫ Gout
▫ Nerve Pain Pacemaker
▫ Anemia
▫ Anxiety
▫ Depression
▫ Osteoporosis
▫ Cancer
▫ Liver Disease
▫ HIV
▫ Cholesterol
▫ Seizures
▫ Osteoarthritis
▫ Rheumatoid Arthritis
▫ Blood Clots
▫ Other:

Diabetes:
▫ Insulin
▫ Non-insulin
▫ Last blood glucose:_____
▫ Last Hg A1c:_____
▫ When?_____

In the last 6 months?

▫ Weight loss
▫ Appetite change
▫ Leg cramps
▫ Blurred vision
▫ Headache
▫ Cough
▫ Palpitations
▫ Shortness of breath
▫ Heart attack
▫ Stroke
▫ Rashes
▫ Chest pain
▫ Masses
▫ Major trauma

Allergies

▫ None ▫ Penicillin ▫ Codeine ▫ Sulfa ▫ Iodine ▫ Anesthetics ▫ Latex ▫ Jewelry
▫ Shrimp ▫ Anti-inflammatories ▫ Other:

Medication Name	Dose	Medication Name	Dose	Medication Name	Dose

Are you on blood thinners or aspirin? ▫ No ▫ Yes List:

Have you had any recent falls? ▫ No ▫ Yes When/How often:

Have you had any stents or peripheral vascular surgery? ▫ No ▫ Yes When/Surgeon:

Are you pregnant or planning a pregnancy? ▫ No ▫ Yes Explain:

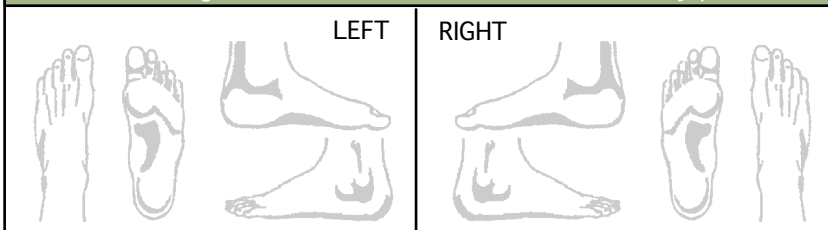
Surgical History - Please list any surgeries you have had, include dates and surgeon's name if possible

Name of Procedure	Date	Surgeon

Do you have any surgeries planned/pending? ▫ No ▫ Yes Details:

Current Foot Problems:

Mark drawings below with numbers 1 and 2 to identify problems



Describe up to 2 main problems in greater detail below

1. Describe your problem and it's cause if you know:
My first problem is: ▫ Left foot ▫ Right foot ▫ Both feet

Is this problem work related: ▫ No ▫ Yes Date: _____

My pain/discomfort began: _____

Pain Scale: 1 2 3 4 5 6 7 8 9 10
(circle) Minimal Moderate Severe Intolerable

It occurs when: _____

Previous medical treatment(s): _____

_____

_____

_____

Additional Problem

2. Describe your problem and it's cause if you know:
My first problem is: ▫ Left foot ▫ Right foot ▫ Both feet

_____

_____

Is this problem work related: ▫ No ▫ Yes Date:
My pain/discomfort began:

Pain Scale: 1 2 3 4 5 6 7 8 9 10
(circle) Minimal Moderate Severe Intolerable

It occurs when:
Previous medical treatment(s): _____

_____

_____

*Medical Infromation Release Form (HIPPA Release)

▫ I acknowledge receiving a copy of the ETFA Notice of Privacy Practices and I hereby authorize the release of information including diagnosis, records, claims and examination rendered to me. This information may be released to:

▫ Spouse: _____

▫ Child(ren): _____

▫ Other: _____

▫ Information is not be released to anyone.

* This Release of information will remain in effect until terminated by me in writing.

Messages

Please Call: ▫ my work ▫ my home
▫ my cell number: _____

if unable to reach me:
▫ you may leave a detailed message
▫ please leave a message asking me to return your call

▫ Other: _____

I authorize the release of any medical information necessary to process this claim and request payment of benefits, government or other, be made to: ETFA

I hereby give permission to the podiatrists of ETFA to examine, treat and perform such procedures as may be necessary for the treatment of my condition.

Signed: _____

Witness: _____

Date: _____