PATIENT INFORMATION SHEET

Patient's Name (Last, First, Middle) _____ Social Security # _____

Age ____ Date of Birth _____ Marital Status (circle one) M / S / D / W Gender (circle one) Male / Female Driver's License # _____

Home Address (Street, Apt. #) _____ (City) _____ (State) _____ (Zip Code) _____

Home Ph. # _____ Work Ph. # (Ext.) _____ Cell Ph. # _____ Pager # _____

Where do you prefer us to contact you: _____

Is it OK to leave a detailed message at this number in your absence? _____

Employer / School Name _____ Occupation _____

Address (Street, Apt. #, City, State, Zip Code) _____

Emergency Contact _____ Relationship _____

Home Address (Street, Apt. #, City, State, Zip Code) _____ Phone # _____

If patient is a minor – Name of person responsible _____ Relationship _____

Home Address (Street, Apt. #, City, State, Zip Code) _____ Phone # _____

INSURANCE INFORMATION (please present insurance card and valid photo ID at time of check in)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name:		
Insurance Holder's Name:		
Relationship to Patient:		
Date of Birth of Ins. Holder:		
Social Security # of Ins Holder:		
ID/Policy #:		
Group #:		
Ins. Customer Service Phone #:		

Do you have other insurance? ___Yes ___No. If yes, please list: _____

I allow release of medical information to the following: (Please list individuals' names and relationship)

No one except myself ____ Spouse: _____Other: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information and certify that it is true and correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for services rendered. I acknowledge that I was provided a copy of the notice of privacy practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

SIGNATURE: _____ DATE: _____

PATIENT MEDICAL HISTORY FORM

Name	Age	Weight	Height	Date Of Birth	Sex (F / M)	Shoe Size
_____	____	_____	_____	_____		_____

List all foot and ankle problems: _____
When did your problem begin? _____
Locate the area of the problem: _____
Describe any pain and/or disability: _____
Is the pain: ___Burning ___Throbbing ___Sharp ___Dull ___Aching Other_____
What causes the problem or makes it worse? _____
What have you tried to alleviate the problem? _____
Is there any other pertinent background information? ___ No _____ Yes Explain: _____
_____
Was it caused by an injury? ___No ___Yes. If Yes, Date of Injury_____Where did it occur? _____
Are there any associated signs or symptoms? ___No ___Yes (explain) _____
Have you been treated for this condition medically before? ____No ___Yes If Yes, When and How?_____
_____
Primary care doctor's name and phone#: _____

CURRENT MEDICATIONS: (Include Vitamins and Supplements Names) _____
_____

ALLERGIC HISTORY (Check all items which you are allergic to)
___I HAVE NO ALLERGIES TO ANY MEDICATIONS
___Penicillin ___Novocaine ___Iodine ___Codeine ___Tape ___Betadine ___Mercurials ___Sulfa Drug
___Aspirin ___Local Anesthesia ___Anti-Inflammatories Others:_____

SOCIAL HISTORY:
Are you diabetic? Yes___No___ Insulin Dependant? Yes___No___ If yes, how long? _____
Do you use Tobacco? Yes___ No___ If yes, how much and how long? _____
Do you drink Alcohol? Yes___ No___ If yes, Socially_____ Excessively_____
Do you use Recreational or nonprescription drugs? Yes___ No___ If yes, how much and how long? _____
Female: Are you or might you be pregnant? Yes___ No___ How many months? _____

MEDICAL HISTORY: (Please check any of the following medical conditions that apply and add any other important problems)

Skin:
___ Abnormal scarring
___ Difficulty healing
___ Dry skin/lips
___ Keloid/Raised or thick scars
___ Other _____

Musculoskeletal:
___ Joint aches/Stiffness
___ Arthritis
___ Artificial joint
___ Feet, leg cramps
___ Foot/Ankle swelling
___ Other _____

Eyes/Ears/Nose/Throat:
___ Visual problems
___ Glaucoma
___ Hearing aid
___ Other _____

Endocrine:
___ Kidney disease
___ Diabetes
___ Thyroid
___ Cancer
___ Gout
___ Other _____

Cont. next page….

Patient Signature: _____ **Date: _____**

CONT.
MEDICAL HISTORY

Infections:
___ Tuberculosis (T.B.)
___ Hepatitis; Type_____
___ HIV/AIDS
___ Other_____

Respiratory:
___ Emphysema
___ Asthma
___ Shortness of Breath
___ Other_____

Gastrointestinal:
___ Liver problems
___ Stomach ulcer
___ Colitis
___ Other_____

Cardiovascular:
___ Heart murmur
___ Artificial heart valve
___ Pacemaker
___ Heart attack
___ Stroke
___ Mitral valve prolapse
___ Chest Pain
___ Heart Disease
___ Heart Arrhythmia
___ Abnormal EKG
___ Other _____

Neurological:
___ Headaches
___ Stroke
___ Seizures
___ Numbness of feet/legs
___ Convulsions
___ Epilepsy
___ Other_____

Hematological:
___ High Blood Pressure
___ Anemia
___ Bleeding Problems
___ Phlebitis
___ Sickle Cell
___ Other_____

Constitutional Symptoms:
___ Fever
___ Recent Weight loss
___ Other_____

Psychiatric:
___ Depression
___ Anxiety ___Other_____

SURGICAL HISTORY: List past surgeries and year: _____
_____

FAMILY HISTORY: (Indicate which immediate relatives have had any of the following diseases)

Diabetes_____ High Blood Pressure_____ Stroke_____ Heart Disease_____
Cancer_____ Lung Disease_____ Hepatitis_____ HIV (AIDS)_____
Bleeder_____ Kidney Disease_____ Other: _____

PREFERED PHARMACY INFORMATION

PHARMACY NAME:_____

PHARMACY ADDRESS:_____

PHARMACY PHONE #: _____

I hereby grant permission to Dr. George Bakatsas, to perform such medical treatment he deems necessary. I understand that I am responsible for disclosing any changes in the above answers that I have provided at all times. I understand that I will need to complete a similar form when treatment consists of a medical problem other than the problem listed above or to update the form on file.

SIGNATURE: _____DATE: _____

George C. Bakatsas, D.P.M., F.A.C.F.A.S.
6849 82nd Street, Suite 102
Lubbock, TX 79424

PAYMENT POLICY

If we are filing your insurance through a contracted plan, it is YOUR RESPONSIBILITY to notify the receptionist that you are on a certain plan and give your insurance card, picture I.D. and/or referral to the receptionist BEFORE SERVICES ARE RENDERED. Should you not have your insurance card and/or referral with you at the time of service, you will be asked to re-schedule your appointment for a time when you can bring the insurance card and/or referral.

DEDUCTIBLES AND CO-PAYMENTS WILL BE COLLECTED AT THE TIME OF THE VISIT, AND WE WILL BILL YOUR INSURANCE FOR THE BALANCE UNDER THESE PLAN PROVISIONS. WE HONOR ALL OUR INSURANCE CONTRACTS AND TAKE ADJUSTMENTS AS WE ARE INSTRUCTED BY OUR PAYORS. AFTER YOUR INSURANCE PAYS AND THE INSURANCE COMPANY SAYS THAT YOU STILL HAVE A BALANCE, YOU WILL BE RESPONSIBLE FOR THE BALANCE.

Our billing office will submit your claims and assist you in any way we reasonably can to help get your claims processed. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. ANY CLAIMS NOT PROCESSED WITHIN 60 DAYS WILL BE TRANSFERRED TO YOUR RESPONSIBILITY.

The majority of services rendered in this office are considered office surgery by your insurance company. This may result in a higher co-payment or charges may be subject to a surgical deductible. As a result, you may be responsible for a higher co-payment, payment of surgical deductible and/or full payment of services rendered at the time of your visit.

If you do not have insurance payment is due at time of service.

If you understand and agree with this policy, please sign below.

Thank you,

Dr. George Bakatsas and Staff

SIGNATURE: _____DATE: _____

George C. Bakatsas, D.P.M., F.A.C.F.A.S.
6849 82nd Street, Suite 102
Lubbock, TX 79424

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative **Date**

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

POLICY FOR RELEASE OF MEDICAL RECORDS

I understand that only copies of Medical records can be released to me or to any doctor's office. Original records are property of this office. I understand that there is a charge of $ 0.50 cents per page for copying of medical records. I must sign consent for the release of this information. I understand that there is a 7-14 day turnaround time for medical records from the time of the signing of consent for release of copying my information.

_____ _____
Signature of Patient or Personal Representative **Date**

HOW DID YOU HEAR ABOUT US?

REFFERRAL
____ Patient Referral. Patient's Name: _____
____ Friend Referral. Friend's Name: _____
____ Relative Referral. Relative's Name: _____
____ Doctor's Referral. Doctor's Name: _____
____ Insurance Referral.

INTERNET WEBSITE
____ Insurance Company Website
____ Our Internet Website: *www.LubbockFootDoctor.com*
____ Other Internet Website: _____

____ **PHONE BOOK**