Trinity Foot Center Lisa J. Brandy D.P.M. | 1801 N. Hampton Road Ste. 340 Desoto, TX 75115 * Phone: 972-293-9650 * Fax: 972-291-2533

PATIENT INFORMATION

Full Name _____

DOB _____/_____/_____ Age_____ ☐ Male ☐ Female

Address _____

City/State/Zip _____

Cell Phone _____ Home Phone_____

Which you prefer to be called on first: ( ) Cell ( ) Home

Email _____

Ethnicity: ☐ NOT Hispanic or Latino ☐ Hispanic or Latino ☐ Decline

Primary language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Black or African American ☐ American Indian ☐ Decline

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer _____Occupation_____

HOW DID YOU HEAR ABOUT US?

☐ Friend	☐ Google	☐ Doctor Referral	☐ Yelp	☐ Insurance	☐ Internet	☐ Other_____

Family physician:_____Phone#_____ Last seen:_____

Doctor who treats your Diabetes (if diabetic) : _____ Last seen: _____

Emergency Contact _____Phone _____Relationship:_____

In case of an emergency, do you want to name someone to make medical decisions on your behalf, if you are not able to?
____No _____Yes Name_____ Relationship:_____Phone No.:_____

Pharmacy _____ Address _____ City_____

My Preferred method of communication in regards to my medical condition

1.) How can we contact you? (check ALL that apply) ☐ Phone ☐ Mail ☐ Email ☐Text message

2.) **Do you consent for our office to leave a detailed message?** ☐ Yes ☐ No

3.) Whom may we release medical information to: _____

INSURANCE INFORMATION:

PRIMARY Insurance Name	**Member ID #:**
Policy Holder Name & Birthday	**DOB: / /**
Policy Holder Employer	

SECONDARY Ins. Name	**Member ID #:**
Policy Holder Name & Birthday	**DOB: / /**

Notification of Changes

If/when any of the above information, (i.e. name, phone number, insurance,) changes, I will provide the updated information promptly.

X_____DATE_____

Patient's Signature or Parent/ Legal Guardian

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MEDICAL HISTORY

PATIENT NAME: _____

State in your own words your medical reason(s) for coming into our office:

_____

_____

Is this visit related to an injury at work? (___) Yes (___) No

Shoe Size: _____ **Height: _____ Weight: _____**	**Are you a current smoker? Yes No** **If no, Are you a former smoker? Yes No**

FOR WOMEN ONLY: ARE YOU PREGNANT? _____IF SO HOW MANY MONTHS? _____
Or ARE YOU BREAST FEEDING? _____

MEDICATIONS- Please list all medications that you currently use:

_____

_____

_____

_____

_____

ALLERGIES- Are you **allergic** to or have you ever reacted to any of the following?:

Yes	No	Aspirin	Yes	No	Lidocaine (local anesthesia)
Yes	No	Band-aids/ tape	Yes	No	Sulfa drugs
Yes	No	Latex	Yes	No	Penicillin
Yes	No	Steroids	O**ther:** _____		

List Past Surgeries: _____

_____

YOUR Past Medical History: Have **YOU** ever **HAD or HAVE** any of the following? **CHECK ALL THAT APPLY**

Musculoskeletal: (__) Arthritis (__) Gout (__) Unsteady gait	**GI:** (__) Stomach Ulcers or Acid reflux **Endocrine:** (__) Diabetes (__) Thyroid disorder
CVS: (__) Blood Thinners (__) Pacemaker (__) Defibrillator (__) Heart Disease (__) High Blood Pressure (__) Kidney disease (__) Stroke	**Psychiatry:** (__) Alzheimer's (__) Depression (__) Anxiety **Social:** (__) Drug Abuse **Immunology:** (__) Cancer (__)HIV/AIDS **Integumentary:** (__) Eczema (__) Foot Odor **(___) NONE OF THE ABOVE**

X_____ _____

Patient's Signature or Parent/ Legal Guardian Date

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OFFICE POLICIES

PATIENT NAME:_____

Authorization to Treat, Assignment of Benefits, and Coordination of Care

I authorize Trinity Foot Center, PC to provide medical evaluation and treatment as deemed medically necessary. I understand I have the right to discuss or refuse any recommended treatment or procedure.
I authorize payment of medical benefits directly to Trinity Foot Center, PC for services provided. I understand I am financially responsible for all co-payments, deductibles, coinsurance, non-covered services, and any remaining balance not paid by my insurance.
I authorize Trinity Foot Center, PC to obtain, review, use, and disclose my health information as necessary for my treatment, payment, and healthcare operations. This includes accessing my medication history through electronic prescribing systems, and requesting, receiving, and sharing medical records, referrals, prior authorizations, diagnostic test results, and other information with my primary care provider, specialists, pharmacies, insurance plans, and other healthcare providers for the purpose of coordinating my care

Non-Covered Services

It is important to understand that some of the services provided to you may not be covered under your current insurance plan. Therefore, it is important that you check with your insurance company to verify your benefits. You will be responsible for full payment of any services not covered by your insurance at the time of your visit.

Products and DME Supplies

All over-the-counter products purchased are non-refundable. All durable medical equipment (DME) such as ankle/foot braces, shoes, and walking boots, etc. are non-refundable once dispensed.

Surgery

Some minor surgical procedures are performed in our office. Most insurance carriers put these in the category of “surgery”, meaning that the procedure may be applied to a surgical deductible or coinsurance. Therefore, you may be billed for an amount over and above the usual visit co-payment at your visit. If the procedure is not covered by your insurance, we will require 100% payment at the time of the surgery.

Appointments

It is our goal to provide services to you in the most comfortable and timely manner possible. In order to achieve this, we ask that you be on time for your appointments. We realize your time is valuable and we endeavor to keep on schedule, while providing each patient with personalized care. However, emergencies do occur, and may cause delays in our schedule. We will try to keep you informed of these delays should they arise. **If you must cancel an appointment, we ask that you kindly notify us at least 24 hours in advance. There is a $35 fee for each no show occurrence.**

Prescriptions

Please allow 24 hours for new prescriptions, refills, or medication change requests to be processed and sent to your pharmacy. Please contact your pharmacy for refills so that a written request can be faxed to our office. No prescription refill or change requests will be handled after regular office hours or on the weekend.

Notice of Privacy Practices

Our office follows all HIPAA and Privacy Practice Acts as required by law. The privacy practice notice is posted in our lobby. Upon request, you will be provided a copy in paper or electronic form. I have read (or had the opportunity to read if I so chose) and understood the notice.

Thank you for choosing us for your foot care needs. If you have any questions regarding these policies, please notify a member of our business office during regular hours. We will do our best to ensure your understanding of our policies so that we may concentrate on you and your care. I acknowledge that I have read and understand the contents of the financial and office policies for Trinity Foot Center, PC.

X_____Date_____
Patient’s Signature or Parent/ Legal Guardian