Irene Hernaez, DPM
Family Foot Center, PLLC
16659 SW Freeway Ste, 201 Sugar Land, TX
Phone: 281-937-0077 Fax: 346-443-6207

Patient Information

Name:_____ Date of Birth: _____/_____/_____

Address:_____

City:_____ Cell/Work/Other:_____

Email:_____ Gender: Male Female Smoker: Yes No

May we leave a message: Patient Spouse Name:_____

Emergency Contact: Name_____ Phone:_____

Race:_____ Ethnicity:_____ Preferred Language:_____

Form of Contact: Phone Email Text Marital Status: Single Married Other:_____

Who referred you? (ie. Newspaper, Doctor's Name, etc.):_____

Who is your Primary Care Doctor?_____

Describe your foot problem:_____

_____

Please list all the medications you are taking (dosages are not necessary):_____

_____

_____

_____

Are you allergic to any of the following: Penicillin Aspirin Codeine Cortisone Iodine

Sulfa Drugs Novocain Tape Other:_____

Do you have any medical conditions? Please check all that apply:

Diabetes	High Blood Pressure	Poor Circulation
Heart Problems	Liver Problems	Kidney Problems
Cancer	Anemia	Other:_____

Preferred Pharmacy (Name & Zip Code):_____

Please list any surgeries you have had with estimated date:_____

_____

Please provide insurance card and picture ID so a copy can be made, or indicate your method of payment.

Your signature gives us permission to treat you, bill your insurance, and share pertinent medical information with other health care providers who may be involved with your care.

Patient/Guardian Signature:_____ Date:_____

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PRIVACY PRACTICES

Your medical information will be maintained in a confidential manner, as required by law. However, we may use your information as necessary for treatment, payment, and health care operations.
Treatment includes sharing information among health care providers involved in your care. For example, we may share information about your condition with the pharmacist to discuss medications or with radiologists or other consultants in order to make the diagnosis. We may need to use your medical information as required by your insurer or HMO to obtain payment for your treatment.

OTHER USES OF YOUR MEDICAL INFORMATION:

- Family members or close friends who are involved in your care or payments for your treatment.
- Disaster relief.
- Appointment reminders.
- As required by law.
- Public health issues, disease prevention, reporting child abuse/neglect.
- Reporting reactions to medications, notice of recalls.
- Audits, inspections, investigations, and licensure.
- Lawsuits.
- Military authorities, if you are a member of the armed forces.
- National security and Intelligence Activities.

YOUR RIGHTS:

- You may request limitations on your medical information. We are not required to agree, but if we do agree, a signed consent will be obtained by our office and we will comply unless information is needed to provide you with emergency treatment.
- You may request communications in a certain way or location, but you must be specific as to how and/or where.
- You have the right to request a copy of your medical records with a signed request on file.
- We may charge a fee for copying, mailing, and supplies.
- You may request a list of disclosures of your medical information that have been made to persons or entitled other than for health care treatment.

Thank you for choosing us as your podiatrist. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which may require you to read and sign prior to treatment.

NAME:_____ REVIEW OF SYSTEMS DATE:_____ DATE OF BIRTH:_____

GENERAL	NO	YES	RESPIRATORY	NO	YES	GANITOURNIARY	NO	YES	PSYCHIATRIC	NO	YES
Chills			Chronis Cough			Dribbling			Anxiety		
Fatigue			Cough			Pain on Urination			Depression		
Fever			Known exposure to TB			Blood in urine			Insomnia/Sleep Problem		
Malaise			Shorthness of Breath			Large amt of Urine			**METABOLIC/ENDOCRINE**		
Night Sweats			Wheezin			Slow Stream			Cold Intolerance		
Weight Gain			Cough Pructive			Urinary Frequency			Heat Intolerance		
Weight Loss			**CARDIOVASCULAR**	**NO**	**YES**	Urinary Incontinence			Excessive Thirst		
EAR/EYE/NOSE/THROAT			Chest Pain			Urinary Retention			Increased Apetite		
Ear Drainage			Leg Pain with Excercise			Urinary Urgency			**MUSCULOSKELETAL**	**NO**	**YES**
Ear Pain			Edema (Ankle Swelling)			**SKIN/HAIR/NAILS**	**NO**	**YES**	Back Pain		
Eye Discharge			Palpitations			Breast Discharge			Joint Pain		
Eye Pain			**GASTROINTESTINAL**	**NO**	**YES**	Breast Lump			Joint Swelling		
Hearing Loss			Abdominal Pain			Brittle Hair			Muscle Weakness		
Nasal Discharge			Blood in Stools			Brittle Nails			Neck Pain		
Sinus Pressure			Change in Stools			Hair Loss			**BLOOD/LYMPH**	**NO**	**YES**
Sore Throat			Constipation			Excess Hair Growth			Easy Bleeding		
Visual Changes			Diarrhea			Hives			Easy Bruising		
Ear pressure			Heartburn			Itching			Swollen Lymph Nodes		
Ear Popping			Loss of Apetite			Mole Changes			**IMMUNOLOGIC**	**NO**	**YES**
Itchy Eyes			Nausea			Rash			Contact Allergy		
Watery Eyes			Vomiting			Skin Lesion			Environmental Allergies		
Red Eyes			**NEUROLOGICAL**	**NO**	**YES**	Eczema			Food Allergies		
Nasal Congestion			Dizziness						Seasonal Allergies		
Nose Bleeds			Extremity Numbness								
Sneezing			Extremity Weakness								
Post Nasal/Throat Drainage			Walking/Gaint Disturbance								
			Headache								
			Memory Loss								
			Seizures								
			Tremors								

HEIGHT:_____ WEIGHT:_____

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COMMERCIAL INSURANCE:

Your insurance policy is a contract between you and your insurance. We will file your insurance claims as a courtesy to you. However, we require copays and deductibles to be paid at the time service is rendered. We will make every effort to verify your insurance eligibility, co-pays, and/or deductibles at the time of your visit. Many times we do not speak to an insurance representative, instead we are dealing with the automated and/or internet to provide us with accurate information. We will honor only the information provided to us at the time of insurance verification. This is regardless of whether you have had previous medical care from other providers, or if you have met your deductible.

MEDICARE PATIENTS:

As you are aware, Medicare only covers 80% of the allowed expenses. If you do not provide proof of a secondary insurance at the time of treatment, then the 20% co-insurance will be collected. As a **SPECIALIST - PODIATRIST** we are required to list your primary care doctor, or other doctor to who you see regularly. His/her name is required to be listed on the claim along with the last date that you saw that doctor. **THIS INFORMATION IS REQUIRED BY MEDICARE. IF YOU CANNOT PROVIDE YOUR DOCTOR'S NAME, THAN A DEPOSIT MAY BE COLLECTED.** If and when Medicare reimburses us, you will then receive a refund. **IF YOU HAVE QUESTIONS REGARDS MEDICARE'S REQUIREMENTS, PLEASE CALL THEIR CUSTOMER SERVICE LINE, AND THEY CAN ASSIST YOU.**

I HAVE READ AND UNDERSTAND THE ABOVE POLICY. MY SIGNATURE BELOW INDICATED THAT I AGREE TO COMPLY WITH THIS POLICY.

Patient Signature:_____ Date:_____