PATIENT PROFILE

Shay Fish, DPM

PATIENT INFORMATION

Patient ID (office use only): _____

Patient Name: _____ Gender: _____

Date of Birth/Age:_____/_____ Marital Status: _____

PatientAddress:_____

_____

_____

Race:_____ Ethnicity_____ Language:_____

Home Phone: _____ Work Phone:_____

Email_____ Patient SSN:_____

Emergency Contact/Relationship to Patient: _____

Employer: _____ Occupation_____

Referring Doctor: _____ Primary Care Provider: _____

Preferred Pharmacy Name and Address: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____

Address_____

_____

City,State,Zip:_____

_____

Home Phone:_____ Work Phone: _____

DOB:_____ Gender: __ M __ F

SSN_____ Relation to Patient: _____

Employer:_____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Who is the Primary Insured Party? ( ) Patient (same as above) ( ) Responsible Party (same as above) ( ) Other (complete below)

Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____ Specialist Copay:_____

Sepcialist Co-insurance:_____

Insured Name:_____ Insured Date of Birth (required):_____

Insured Address: _____

Insured SSN: _____ Insured Gender: __ M __ F

Insured Relationship to Patient: _____

Insured Employer: _____ Insured Occupation: _____

Member ID: _____

Policy Group_____

SECONDARY INSURANCE INFORMATION

Who is the Secondary Insured Party? ( ) Patient (same as above) ( ) Responsible Party (same as above) ( ) Other (complete below)

I Insurance Name: _____

Insurance Address: _____

Insurance Phone: _____ Specialist Copay:_____

Sepcialist Co-insurance:_____

Insured Name:_____ Insured Date of Birth (required):_____

Insured Address: _____

Insured SSN: _____ Insured Gender: __ M __ F

Insured Relationship to Patient: _____

Insured Employer: _____ Insured Occupation: _____

Member ID: _____

Policy Group_____

AUTHORIZATION AND ACKNOWLEDGEMENT

_____ I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above name practice to release any information acquired in the course of my treatment to my insurance company, employer, physicians, institutions or third party payers, as required for certain claims filed.

_____ I / We authorize direct payment to be made to the above named practice for any and all medical or Surgical services rendered. I / We understand if any services or charges are not covered by my Insurance carrier or my eligibility cannot be verified, I / We are responsible for all charges incurred.

_____ I / We consent to treatment necessary for the care of the patient indicated on this form.

_____ I / We acknowledge that I / We was/were provided a copy of the *Notice of Privacy Practices* and that I / We have read (or had the opportunity to read if I so choose) and understand the Notice.

_____ I / We authorize the following person(s) to inquire about my private health care information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Signature of Patient / Parent / Guardian / Insured

_____

Printed Name

_____

Date

E-MED HISTORY DOWNLOAD CONSENT

I agree that Dr. Shay Fish (Texas Foot Surgeons/Hill Country Foot Surgeons)may download my medication history from the Surescripts Pharmacy Clearinghouse. I understand that this medication history may reflect prescription medications prescribed to me by doctors not employed with this practice and such information will be used in my care and treatment.

_____

Signature of Patient / Parent / Guardian / Insured

_____

Printed Name

_____

Date

PATIENT MEDICAL HISTORY

Today's Date: _____

Patient Name: _____ Date of Birth:_____

What is your height? _____ Weight? _____ Shoe Size? _____

Are you diabetic? ( ) Yes ( ) No

Tell us about your problem:

Please describe: _____

_____

Is your problem with the:

__ left foot __ right foot __ both feet __ other:_____

How long have you had this problem / pain? _____(Give number)

Days weeks months years (circle)

Is this an injury? __Yes __ No Work Related? __ Yes __ No

If yes, date of injury? _____

Have you been treated by anyone else for this problem?__Yes __ No

When? _____

By whom? _____

What was done? _____

Do you have or have you ever been treated for:

( ) Stroke	( ) Heart attack	( ) High blood pressure
( ) Phlebitis	( ) Heart disease	( ) A heart condition
( ) Diabetes	( ) Poor circulation	( ) Headaches
( ) Hepatitis	( ) Liver disease	( ) Anemia
( ) Gout	( ) Arthritis	( ) Osteoporosis
( ) Sciatica	( ) Rheumatic Fever	( ) Lyme's Disease
( ) Alzheimer's	( ) Keloid / Thick scar	( ) Hearing/Ear disorder
( ) Epilepsy	( ) Nerve Disorder	( ) Psychiatric disorder
( ) Glaucoma	( ) Kidney disease	( ) Thyroid problem
( ) Asthma	( ) Lung disease	( ) Tuberculosis
( ) Cancer	( ) Stomach Ulcer	( ) Back Problems
( ) Foot/leg cramp	( ) Phlebitis/DVT	( ) Stroke
( ) Foot Ulcers	( ) Varicose Veins	( ) ***NONE of these***

( ) Other: _____

Do you have a history of foot ulcers? __ Yes __ No

Do you have vascular grafts? (if yes explain below) __ Yes __ No

Do you have joint implants? (if yes explain below) __ Yes __ No

Do you have replacement heart valves? __ Yes __ No

Are you now under active chemotherapy? __ Yes __ No

Have you had any surgery? (if yes explain below) __ Yes __ No

Surgery Date w/complications of:

_____

_____

Allergies: Is there a history of skin reactions or other outward re-action or sickness following an injection, oral or topical application of

	Yes	No		Yes	No
Penicillin	___	___	Empirin, Tylenol	___	___
Other antibiotics (list below)	___	___	Morphine	___	___
Advil, Aleve or Motrin	__	__	Codeine	__	__
Demerol	___	___	Sulfa drugs	___	___
Other narcotics (list below)	___	___	Adhesive tape	___	___
Novocaine	___	___	Shrimp,Iodine,Merthiolate	___	___
Other anesthetics (list below)	___	___	Any other drugs	___	___
Aspirin	___	___	Others: _____		

Tell us about your pain / discomfort:

Please circle the severity of your pain / discomfort:

1 2 3 4 5 6 7 8 9 10 Worst

Please describe the pain:

__ Shooting pain __Itiching __ Tingling

__ Burning pain __ Dull pain __ Numbness

__ Throbbing pain __Aching pain __ Sharp pain

__ Other: _____

My pain / problem occurs:

__ when walking __ when not walking

__ with shoes __ without shoes

__ all the time __ Other: _____

Describe any self treatment you have performed:

_____

Do you have family members who have had:

Diabetes_____ Foot problems_____

Arthritis_____Hearth attack_____

Stroke_____ High blood press_____

Cancer_____ Birth defects_____

# of childbirths__ Are you currently pregnant? _____

Are you slow to heal after cuts? __ Yes __ No

Any abnormal bruising, bleeding or scarring? __ Yes __ No

Do you smoke now? __ Yes __ No Pack/day __ years___

Did you ever smoke? __ Yes __ No Pack/day __ years___

If you quit, when did you do so? _____

Alcoholic beverages? (circle one)

None Rarely Moderately Daily Quit

Recreational Drugs? (circle one)

None Rarely Moderately Daily Quit

Current Medications? __ Yes __ No

Name Dose How often?

_____

_____

_____

Did you previously or do you now wear:

Shoe inserts? ____ Still using them? ____ Help? ____

Orthotics? ____ Still using them? ____ Help? ____

The orthotics were obtained from: ( ) another podiatrist

( ) an orthopedist ( ) a physical therapist ( ) a chiropractor

( ) other _____

How many waking hours are spent on your feet? ____

Preferred shoe for work? _____

Preferred shoe for home? _____

Preferred shoe for recreation? _____

List the sports/type of dance your active in: _____

_____

_____ _____ _____

Signature of Patient / Parent / Guardian Printed Name Date