

Name _____ Phone#: () _____
Last First MI Cell PH#: () _____

Mailing Address _____ City _____ ST _____ ZIP _____

S.S.#: _____ Sex M / F

Marital Status _____

Birthdate ____ / ____ / ____

Language _____

Race _____

Employer _____ Work PH#:() _____

Email _____

Insurance Information

Primary Insurance _____

Policy Holder Name _____

Employer _____

SSN: _____ Birthdate: ____ / ____ / ____

Relation to Patient _____

Secondary Insurance _____

Policy Holder _____

Employer _____

SSN: _____ Birthdate: ____ / ____ / ____

Relation to Patient _____

Emergency Contact

Name _____ Relation to Patient _____

Ph#:() _____

If accident, was it related to work ___ auto ___ or other ___? List date of injury _____

And a brief description of how it happened?

Consent for Treatment

To the best of my knowledge, the information given is correct. I hereby give my permission to Precision Podiatry, its physicians to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature of Patient/Guardian_____Date_____

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES INFORMATION _____(INITIALS).

Consent to Bill Insurance

Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your contract with them and with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid by your insurance. We will assist you in receiving reimbursement as much as possible. But you are responsible for you bill. By signing this you understand and agree that (regardless of insurance status), you are ultimately responsible for the balance of your account for any professional services rendered. You certify that all the information given is true and correct to the best of your knowledge. You will notify us of any changes in your status or the above information.

No show policy as of August 1, 2001: Patients arriving 15 minutes past their appointment time may be rescheduled. Any appointment rescheduled within less then 25 hours notice or no show appointments are subject to a \$25.00 fee.

Your signature is necessary for us to process any information claims and to ensure payment of services rendered.

The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Precision Podiatry and its physicians. This assignment will rmain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature_____Date_____

The Medicare Patient

I request that payment of authorized Medicare Benefits be made to me, or on my behalf to Precision Podiatry and its physicians for any services furnished to me by the provider. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents needed to determine benefits, of the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature_____Date_____

Jeffrey R. Cohen DPM FACFAS Brenda Cohen DPM Jon Smedley DPM FACFAS
7200 Wyoming Springs Suite 1150 Round Rock, Texas 78681 (512) 255-0125 Fax (512) 255-0153
1103 Cypress Creek Suite 101 Cedar Park, Texas 78613 (512) 336-2300 Fax (512) 336-2301

Patient: _____ **DOB** ___/___/___ **Date:** _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Reason for visit

Drug Allergies:

Medications:

Pharmacy Name and Location/phone number _____

Circle One: **Smoker** **Non-Smoker** **Former Smoker**
Alcohol Use: Yes No **Recreational Drug Use:** Yes No

Medical History (please check all that apply)

- Rheumatic Fever
- Polio
- Diabetes Mellitus
- High Blood Pressure
- Stroke
- Hepatitis
- Gout
- Asthma
- Cancer
- Liver Disease
- Kidney Disease
- Lung Disease
- Stomach Ulcer
- Heart Condition
- Headaches
- Anemia
- Osteoporosis
- Psychiatric Disorder
- Thyroid Problem
- Tuberculosis
- Other _____

List Surgeries (include dates)

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Family History (check all that apply)

- Diabetes**
 - Arthritis**
 - Stroke**
 - Cancer**
 - Heart Attack**
 - High blood Pressure**
 - Birth Defects**
 - Anesthesia Reaction**
 - Bleeding Problems**
 - Other** _____
-

Are you currently suffering from any problems listed below? (Please circle all that apply)

Head: chronic headaches, concussions, dizziness, loss of consciousness

Eyes: Glasses, contacts, double vision, blurred vision, blindness, glaucoma, cataracts

Ears: Decrease or loss of hearing, tinnitus, chronic earaches, drainage or infections

Throat: chronic tonsillitis, laryngitis, dysphasia, loss of speech, thyroid disorder

Nose: chronic drainage, blockage, epistaxis, sinusitis

CVS: heart attack, high blood pressure, rheumatic fever, chest pain, shortness of breath, fluttering, heart murmur, valvular disease, anemia

Respiratory: asthma, difficulty night breathing, TB, pleurisy, emphysema, pneumonia

G.I: peptic or duodenal ulcer, chronic nausea, vomiting, diarrhea, constipation, weight gain or loss, jaundice, hepatitis, gall bladder disease, gallstones, blood in stool, hematemesis, colitis, diverticulitis, polyps, appetite disorders

G.U.: chronic kidney or bladder infections, stones, dysuria, pyuria, hematuria, venereal disease

GYN: dysmenorrhea, amenorrhea

Musk: gout, rheumatoid arthritis, osteoarthritis, trauma, fracture, dislocations

Please tell us whom we can thank for referring you.

Name _____

Please tell us whom to coordinate your care.

**Physicians name and
number** _____