HISTORY AND PHYSICAL

Name:_____ **DOB:**_____/_____/_____ **Chart Number:**_____

Medical History: ☐ Alcoholism ☐ Blood Disorders ☐ Circulation Problems ☐ Musculoskeletal ☐ Breathing
☐ Sleep Apnea ☐ Gout ☐ Liver Disease ☐ Heart Disease ☐ Allergies ☐ Asthma
☐ Depression ☐ Anxiety ☐ Mental Illness ☐ Heart Murmur ☐ Kidney Disease ☐ Stomach/Bowel
☐ Blood Clot ☐ Cancer ☐ Hepatitis ☐ High Blood Pressure ☐ High Cholesterol ☐ HIV
☐ Artery Disease ☐ Stroke ☐ Skin Disorders ☐ Neuropathy_____ ☐ Arthritis _____ ☐ Thyroid_____
Are you pregnant? ☐ Y ☐ N **Are you nursing?** ☐ Y ☐ N **Are you Diabetic?** ☐ Y ☐ N (Type 1) (Type 2)

Surgical History: ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on your Foot/Ankle or anywhere else on your body? ☐ Y ☐ N
If yes, please describe: _____
Do you have any artificial joints? ☐ Y ☐ N (if so where _____) Do you have an artificial heart valve? ☐ Y ☐ N

Social History: Do you smoke? ☐ Y ☐ N (if yes how many packs a day?) ☐1 ☐2 ☐3 ☐Other___ For how long? _____
Do you drink alcohol? ☐ Y (every day 5-7 days/week) ☐ Y (occasionally/socially) ☐ N (Never/rarely)
Do you use recreational drugs? ☐ Y (every day 5-7 days/week) ☐ Y (occasionally/socially) ☐ N (Never/rarely)
Have you ever had a substance abuse problem? ☐ Y (current) ☐ Y (in the past) ☐ N (never)
Please describe your substance abuse problem:_____
Do you exercise regularly? ☐ N (I do not exercise) ☐ Y (forms of exercise)_____

Family History: Is there any family of a blood relative? (Please indicate which family member) ☐ **ADOPTED**

☐ Alzheimer's	_____	☐ Cataracts	_____	☐ Heart Disease	_____
☐ Arthritis	_____	☐ Circulation Problems	_____	☐ Hypertension	_____
☐ Bleeding Disorders	_____	☐ Depression	_____	☐ Neurological	_____
☐ Blood clot	_____	☐ Diabetes	_____	☐ Stroke	_____
☐ Cancer	_____	☐ Emphysema	_____	☐ Other	_____

Review of Systems:

Cardiovascular ☐ Leg pain/swelling ☐ Chest Pain ☐ Cold Feet ☐ Fainting ☐ Palpitation ☐ Valve Problems ☐ PVD ☐ **NONE**

Genitourinary ☐ Blood in urine ☐ Hesitancy ☐ Inc. Urgency ☐ Kidney Disease ☐ Kidney Stones ☐ Dec. Urgency ☐ **NONE**

Gastrointestinal ☐ Abdominal Pain ☐ Heartburn ☐ Blood in Stool ☐ Vomiting ☐ Ulcers ☐ Constipation ☐ Diarrhea ☐ **NONE**

Integumentary ☐ Athletes Foot ☐ Nail Abnormalities ☐ Keloids ☐ Itching ☐ Dry skin ☐ Eczema ☐ Blisters ☐ **NONE**

Hematologic ☐ Ulcerations ☐ Sickle Cell Disease ☐ Anemia ☐ Clotting Disorder ☐ Leukemia ☐ Blood Thinners ☐ **NONE**

Neurological ☐ Tingling ☐ Seizures ☐ Paralysis ☐ Tremors ☐ Numbness ☐ Vertigo ☐ Loss of Balance ☐ **NONE**

Musculoskeletal ☐ Back Pain ☐ Joint Swelling ☐ Sciatica ☐ Limited Motion ☐ Joint Pain ☐ Gait ☐ Instability ☐ **NONE**

Respiratory ☐ Chest Pain ☐ Wheezing ☐ Coughing ☐ Shortness of Breath ☐ COPD ☐ Emphysema ☐ Asthma ☐ **NONE**

PLEASE READ AND SIGN *The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician/staff of any and all updates to the information listed above.*

Patient Signature: _____ Date: ____/_____/_____

MEDICAL RECORD

Name:_____ **DOB:**_____/_____/_____ **Chart Number:**_____

Is this an Injury Related to Work / Workman Compensation? ☐ Y ☐ N

Chief Complaint:_____

_____

_____ **RIGHT** **LEFT** **BOTH**

What is your current pain level? _____/ 10 ☐ Constant ☐ Intermittent (1 being no pain 10 being the worst)

How long has this bothered you? 1 2 3 4 5 6 7 ☐ Days ☐ Weeks ☐ Months ☐ Years

What treatments have you tried?_____

The pain is: ☐ Dull ☐ Sharp ☐ Aching ☐ Throbbing ☐ Cramping ☐ Itching ☐ Popping ☐ Burning ☐ Tingling

☐ Clicking ☐ Shooting ☐ Stabbing ☐ Other_____

Have you fallen in the past 6-12 months? ☐ Y ☐ N

Smoking Status:

☐ Current ☐ Former ☐ Never
☐ Heavy Tobacco Use ☐ Light Tobacco Use
☐ Other _____

Vitals: **Shoe Size:** _____

Blood Pressure: _____/_____

Height: ____'____ **Weight:**_____

Primary Care Physician: _____ **Phone:**_____

Date Last Seen: _____/_____/_____ **(Required by Medicare)*

Pharmacy Name: _____ **Phone:**_____

Pharmacy Address:_____ **City/State/Zip:**_____

Current Medication:

☐ No Known Medications ☐ See Attached List

Medication:_____
Medication:_____
Medication:_____
Medication:_____
Medication:_____
Medication:_____

Use back of this form if more room is needed

Allergies:

☐ No Known Drug Allergies ☐ See Attached List

Name:_____ **Reaction:**_____
Name:_____ **Reaction:**_____
Name:_____ **Reaction:**_____
Name:_____ **Reaction:**_____
Name:_____ **Reaction:**_____
Name:_____ **Reaction:**_____

Use back of this form if more room is needed

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physicians/staff of any and all updates to the information listed above.

Patient Signature: _____ Date: ____/_____/_____

PATIENT DEMOGRAPHICS

Name:_____ **DOB:**_____/_____/_____ **Chart Number:**_____

Sex: ☐ M ☐ F Marital Status: ☐ Single☐ Married☐ Widowed☐ Divorced **SS#**_____-_____-_____

Email:_____

Address:_____ **City:**_____ **State**____ **Zip**_____

Home #:_____ **Cell #:** _____ **Other #:**_____

Occupation:_____ **Employer:**_____ **Phone:**_____

EMERGENCY CONTACT **Name:**_____ **Phone #:**_____

Ethnicity/Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline to answer

Primary Language: ☐ English ☐ Spanish ☐ ASL ☐ Other_____

Privacy Information Preferences

Have you completed any advanced directives? ☐ Y ☐ N Does anyone have Medical POA over you ☐ Y ☐ N

Do you want to exempt from public reporting? ☐ Y ☐ N Can we send mail to the address listed on file? ☐ Y ☐ N

Can we call the phone number on file? ☐ Y ☐ N Can we leave a voicemail on machine? ☐ Y ☐ N

Who can we leave messages with? ☐Spouse ☐ Parent ☐ Child ☐ Other_____ Name:_____

How did you hear about out office? ☐ Physician ☐ Website ☐ Phonebook ☐ Family ☐Friend ☐ Other _____

Primary Insurance:_____ **Are you the insured?**☐ Y ☐ N

Member ID #: _____ **Group #:**_____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other **Employer:**_____

Subscriber Name:_____ **DOB:**___/____/____ **Sex:** ☐ M ☐ F

Address:_____ **City:**_____ **State**_____ **Zip** _____

Secondary Insurance:_____ **Are you the insured?**☐ Y ☐ N

Member ID #: _____ **Group #:**_____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other **Employer:**_____

Subscriber Name:_____ **DOB:**___/____/____ **Sex:** ☐ M ☐ F

Address:_____ **City:**_____ **State**_____ **Zip**_____

PLEASE READ AND SIGN

The information on my intake forms is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician/staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of information): I authorize the release of any medical information necessary to process the claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practices Notice. (Medication History): I Authorize the Doctors office to retrieve my medication history.

Patient Signature: _____ Date: ____/_____/_____

PATIENT RIGHTS AND RESPONISBILITIES

Responsibilities:

- ✓ Follow all of your physician's instructions.
- ✓ Be on time for all of your appointments. Please advise that if you are more than 15 minutes late you may have to reschedule your appointment.
- ✓ Notify our office of any changes in address, phone number, or insurance.
- ✓ Bring your insurance card(s) and Photo ID to every appointment as this is required for you to be seen.
- ✓ Advise that all Co-Payments and Co-Insurance are due at the time of service. *Payment of benefits are subject to all terms, conditions, limitations and exclusions of the members contract at the time of service.
- ✓ If you have questions about your benefits/coverage you may ask our staff for an explanation of the breakdown of coverage/benefits we have received from your insurance company.
- ✓ If you are unable to keep your appointment you must notify our office at least 24 hours prior to avoid a late cancellation or no-show fee.
- ✓ Please respect all fellow patients, physicians, and our office staff. Unkind or hostile behavior towards any patients, physicians, and our office staff will result in termination of care.
- ✓ Please allow 48-72 hours for all prescription refills.

Rights:

- ✓ Receive the best quality Healthcare from our office, physicians, and staff.
- ✓ The right to ask for information about your benefits/coverage and healthcare costs.
- ✓ The ability to be/stay involved with any and all decisions regarding the medical care you receive.
- ✓ Expect that all communications and records pertaining to your healthcare will be treated as confidential following all HIPPA guidelines.
- ✓ The right to refuse treatment and/or seek a second opinion.

_____/_____/_____

Print Patient Name **Date of Birth**

_____/_____/_____

Signature of Patient / Representative **Date**

DIMITRIOS MANTZOROS DPM **TIMOTHY CASPERSON DPM** **GURPREET MUKKER DPM**

OFFICE AND FINANCIAL POLICIES

Welcome and thank you for choosing Conroe Foot Specialists, Huntsville Podiatry Associates, and/or Woodland Foot Specialists for your podiatric care. We are committed to providing you with the highest quality healthcare in an efficient and cost-effective manner. We hope that providing you with our policies in advance we can prevent any misunderstandings or frustrations at your time of visit.
PLEASE INITIAL ALL OF THE FOLLOWING:

Initials:_____ **Insurance:** The patient is responsible for knowing how their insurance benefits including deductibles and copay-ments. We will gladly file your insurance claim on your behalf; however, we will not be involved in disputes between you and your insurance company regarding coverage and or policy benefits. You are responsible for timely payment on your account.

Initials:_____ **Referrals:** All patients with an ***HMO*** policy ***REQUIRE*** a referral to see any specialist. If you are part of an ***HMO*** policy, your Primary Care Physician (PCP) must generate a referral through your insurance company under one of our physician's names. Please advise the physician listed on your referral is the only physician in our practice authorized to provide you care. ***It is the patient's responsibility to provide/acquire a referral before you have scheduled an appointment. If a referral is not obtained prior to your visit your appointment will be rescheduled NO EXCEPTIONS.***

Initials:_____ **Check-In:** Please arrive about 15 minutes before your scheduled appointment time, so that all paperwork may be completed before you see the physician. If you are unable to complete the requested paperwork at the time of your appointment your visit may be rescheduled. If you require language assistance you must bring someone to accompany you to your visit who can translate for you. ***You must bring your current insurance card(s), and valid Photo ID to every office visit.*** On follow up appointments you may be asked to verify demographic & insurance information, to keep our records up to date. **Full payment is due at the time of service.**

Initials:_____ **Check-Out:** Please be prepared to pay for your current visit as well as any past due balances on your account. Copays, Deductibles, Co-Insurance percentages, and/or fees for non-covered services will be required at the time of service. For your convenience we accept Cash, Check, and Credit Cards.

Initials:_____ **Late Arrivals:** We do our best to keep to our schedule. When a patient arrives late without notice, it affects the entire schedule and/or other patients who arrived for their appointments on time. ***If you arrive more than 15 minutes late to your appointment you will be asked to reschedule so that other patients are not inconvenienced.***

Initials:_____ **Cancellation/No-Show:** We ask you to please notify our office ***24 hours in advance*** if you are unable to keep a scheduled appointment to avoid a cancellation or no-show fee.

Initials:_____ **Collections:** You will receive at least 3 statements from our office if any balances are owed. Please ensure to make payment arrangements to keep your account balance paid. If your address changes it is your responsibility to inform our office so that me may update our records, otherwise your account will be turned over to collections due to a voided address. ***Once your account acquired a bad debt or is sent to collections, we will not provide services/you will not be seen until the account is paid in full.***

Initials:_____ **Dishonored Checks:** A $30 service fee will be assessed on all dishonored checks. The full amount of the check written plus the $30 fee must be paid with cash or by credit card. ***If payment is not received within 5 business days your information will be filed with the Montgomery/Walker County Hot Check Division.*** We will be unable to see you until your full payment is made. If you have 2 occurrences, we will no longer accept checks as a form of payment from you.

Initials:_____ **Prescriptions:** It is the patient's responsibility to contact the pharmacy prior to running out of medication. You must ask the pharmacy to fax us a refill request, no refill requests will be accepted over the phone. Please advise it can take up to 48-72 hours to be refilled. ***We are not a pain management practice therefor no narcotic pain medication prescriptions will be provided to patients will acute and or chronic pain. If your pain is more long term or on going, we will gladly refer you to the appropriate medical professionals for treatment such as a pain management physician.***

Initials:_____ **Disability/FLMA Forms:** A $25 fee will be charged for all Disability/FMLA forms completed by our physicians. ***This fee is applied per fill out session.***

I have read, understood, and agreed to all of the above office and financial policies listed. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize the release of information necessary for insurance filing, and pre-certifications by signing this statement.

_____/_____/_____

Print Patient Name **Date of Birth**

_____/_____/_____

Signature of Patient / Representative **Date**

DIMITRIOS MANTZOROS DPM **TIMOTHY CASPERSON DPM** **GURPREET MUKKER DPM**

AUTHORIAZTION TO RELEASE HEALTHCARE INFORMATION

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

By completing this form, I am authorizing the release of any information about my medical records and health concerns to the following persons that I have listed. This does not include other healthcare providers or their offices. I understand that I may choose not to authorize the release of my medical information at any time. **Example(s) [Spouse, Parent(s), Children, Friend(s), Caregivers(s) Etc.)**

Name:_____Relationship:_____ Initials_____

Name:_____Relationship:_____ Initials_____

Name:_____Relationship:_____ Initials_____

Name:_____Relationship:_____ Initials_____

Name:_____Relationship:_____ Initials_____

Name:_____Relationship:_____ Initials_____

Can our office leave detailed message on your answering machine/voicemail? ☐ Y ☐ N

I understand that my signed consent is required to release all healthcare information related to testing/diagnosis, and/or treatment of any condition/disease.

This authorization expires three years from the date signed.

HIPPA. Section 164.508 of the final privacy rule states that covered entities may not use or disclose protected health information (PHI) without a valid authorization, except as otherwise permitted or required in the privacy rule.

_____/_____/_____

Print Patient Name **Date of Birth**

_____/_____/_____

Signature of Patient / Representative **Date**

ACKNOWLEDGEMENT/NOTICE OF PRIVACY PRACTICES

I have been provided a copy for review(*accessible online and/or upon request from the office)* of the Conroe Foot Specialists, Huntsville Podiatry Associates, and/or Woodland Foot Specialists 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 upon request.

Notice:

The physicians of Conroe Foot Specialists, Huntsville Podiatry Associates, and/or Woodland Foot Specialists: (Dr. Dimitrios S. Mantzoros D.P.M. F.A.C.F.A.S., Dr. Timothy C. Casperson D.P.M. F.A.C.F.A.S., Dr. Gurpreet K. Mukker D.P.M. F.A.C.F.A.S.) may or may not have financial interest in the following facilities: Memorial Herman Surgical Center Conroe & Aspire Outpatient Radiology LLP.

**The HIPPA Privacy Rule requires health plans and covered healthcare providers to develop and distribute a notice that provides a clear, user friendly explanation of individuals rights with respect to their personal health information and the privacy practices of health plans and healthcare providers.*

_____/_____/_____

Print Patient Name **Date of Birth**

_____/_____/_____

Signature of Patient / Representative **Date**