Practice: CONROE FOOT SPECIALISTS **Today's Date:**

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

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

E-mail: _____ **Spouse/Partner Name:** _____

E-mail newsletters, reminders, statements, etc. **Emergency Name:** _____ **Phone:** _____

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

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

Employer: _____ **Phone:** _____

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

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

What is the reason for your visit today? _____

_____ **Result of accident or work injury?** ☐Yes ☐No

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

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 and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

History and Physical

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

Medical History:
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other *(specify)* _____ ☐ HIV ☐ CVA
Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

Surgical History ☐ None ☐ Appendectomy ☐ C-Section ☐ Angioplasty ☐ Bypass ☐ Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

Social History
Do you smoke? ☐ Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐ Yes, everyday (5-7 days/week) ☐ Yes, occasionally/socially ☐ No/Rarely
Substance abuse: ☐ Yes, I have a current substance abuse problem. Please specify: _____
☐ Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐ sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

Family History Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's	_____	☐ Depression	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding disorders	_____	☐ Emphysema	_____
☐ Blood clot	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Neurological	_____
☐ Circulation problems	_____	☐ Strokes	_____
☐ Other (specify):	_____		

Review of Systems *(Please check the box if you currently have any of these symptoms or check "NONE")*

Cardiovascular	☐ leg pain when walking	☐ fever	☐ chest pain/pressure	☐ leg swelling	☐ cold hands/feet
	☐ fainting	☐ palpitations	☐ vascular disease	☐ valve problems	☐ **NONE**
Genitourinary	☐ blood in urine	☐ hesitancy	☐ incontinence	☐ increased urgency	
	☐ decreased frequency	☐ excessive urination	☐ kidney disease	☐ kidney stones	☐ **NONE**
Gastrointestinal	☐ abdominal pain	☐ heartburn	☐ blood in stool	☐ vomiting	☐ ulcers
	☐ diarrhea	☐ trouble swallowing	☐ decrease appetite	☐ increase appetite	☐ constipation ☐ **NONE**
Integumentary	☐ athletes foot	☐ nail abnormalities	☐ keloids	☐ itchiness	☐ dry, scaly skin ☐ **NONE**
Hematologic	☐ lower leg ulcers	☐ sickle cell disease	☐ anemia	☐ blood thinners	☐ clotting disorders ☐ **NONE**
Neurological	☐ tingling	☐ weakness	☐ seizures	☐ numbness	☐ headaches
	☐ tremors	☐ paralysis			☐ **NONE**
Musculoskeletal	☐ back pain	☐ joint swelling	☐ muscle weakness	☐ muscle pain	☐ neck pain
	☐ sciatica	☐ joint stiffness	☐ joint pain	☐ joint instability	☐ arthritis ☐ **NONE**
Respiratory	☐ chest pain	☐ wheezing	☐ COPD	☐ coughing	☐ snoring
	☐ shortness of breath	☐ emphysema			☐ **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 and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Practice: CONROE FOOT SPECIALISTS **Today's Date:**

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to specify

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Declined to specify

Preferred Language: _____ ☐ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Referring Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other:

Name(s): _____

Smoking Status

☐ Current Every Day ☐ Smoker, Current Status Unknown

☐ Current Some Day ☐ Heavy Tobacco ☐ Unknown If Ever

☐ Former ☐ Never ☐ Light Tobacco ☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No **Were you injured from the fall?** ☐ Yes ☐ No

Have you completed any Advanced Directives? ☐ Yes ☐ No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical 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 this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Rev 1/21/2015

DR. DIMITRIOS MANTZOROS | DR. TIMOTHY CASPERSON | DR GURPREET MUKKER

Office and Financial Policies

Welcome and thank you for choosing Conroe Foot Specialists, Huntsville Podiatry Associates and/or Woodlands Foot Specialists for your podiatric care. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that providing you with our policies in advance we can prevent any misunderstandings or frustration at the time of your visit. ***Please initial all of the following:***

Initials:_____ Insurance: The patient is responsible for knowing their insurance benefits including deductibles and co-payments. If you are part of an ***HMO*** policy, you will require a referral. We will gladly file your insurance claim on your behalf, however we will not be involved in disputed 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*** referrals 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 patients 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 any requested paperwork at the time of your appointment your visit may be rescheduled. If you require language assistance you must have someone accompany you to your visit who can translate for you. ***You must bring your current Insurance Cards and a Valid Photo ID to every office visit.*** On follow up appointments you may be asked to verify demographic and insurance information, so our records remain up to date. Payment is due in full at the time of service.

Initials:_____ Check-out: Please be prepared to pay for your current visit as well as any past balances on your account. 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 patient 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_____ Cancellations/No Shows: 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 we may update our records, otherwise, your account will be turned over to collections due to a voided address. Once your account is sent to collections, ***you may 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 Montgomery/Walker County Hot Check Division.*** We will be unable to see you until payment is made in full. If you have 2 occurrences we will no longer accept checks as a form of payment from you.

Initials_____ Prescriptions: It is the patients responsibility to contact the pharmacy prior to running out of medication. You must ask the pharmacy to fax us a refill request. Please advise it can take up to 48-72 hours to be refilled. ***We are not a pain management practice therefore no narcotic pain prescriptions will be provided to patients with chronic pain. If your pain is more long term or ongoing, we will gladly refer you to the appropriate professional for treatment such as a pain management physician.***

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

I have read, understand, and agree to all the above office and financial polies 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-certification by signing this statement.

_____

Print Patient Name DOB

_____

Signature of Patient/Representative Date

DR. DIMITRIOS MANTZOROS | DR. TIMOTHY CASPERSON | DR GURPREET MUKKER

Patients' Rights and Responsibilities

Responsibilities:

- ✓ Follow all of your physician's instructions.
- ✓ Be on time for your appointments. Please advise 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 member's contract at time of service.
- ✓ If you have any questions about your benefits you may ask our staff for an explanation of the breakdown of benefits we have received from your insurance company.
- ✓ Please allow 48-72 hours for all prescription refills.
- ✓ Please respect fellow patients, physicians, and our office staff.
- ✓ If you are unable to keep an appointment you must notify our office at least 24 hours prior to that appointment to avoid any no show fees.

Rights:

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

_____

Print Patient Name DOB

_____

Signature of Patient/Representative Date

DR. DIMITRIOS MANTZOROS | DR. TIMOTHY CASPERSON | DR GURPREET MUKKER

Authorization to Release Health Care Information

Patients 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 (EXAMPLE: Spouse, Parent (s), Children, Friend (s), Caregiver (s). This does not include other doctor's offices. I understand that I may choose not to authorize the release of my medical information at any time.

Name:_____ Relationship:_____ Initials_____

Name:_____ Relationship:_____ Initials_____

Name:_____ Relationship:_____ Initials_____

Name:_____ Relationship:_____ Initials_____

Name:_____ Relationship:_____ Initials_____

Name:_____ Relationship:_____ Initials_____

Is it ok for our office to leave detailed messages on your answering machine/voicemail? YES NO

This authorization expires three years from the signed date

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

HIPAA. 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 DOB

_____

Signature of Patient/Representative Date

DR. DIMITRIOS MANTZOROS | DR. TIMOTHY CASPERSON | DR GURPREET MUKKER

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 Woodlands 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 Woodlands Foot Specialists: (Dr. Dimitrios S. Mantzoros D.P.M. Dr. Timothy C. Casperson D.P.M. ,Dr. Gurpreet K. Mukker D.P.M.) may or may not have financial interest in the following facilities: Memorial Herman Surgical Center Conroe & Aspire Outpatient Radiology LLP.

**The HIPAA Privacy Rule requires health plans and covered health care 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 health care providers.*

Print Patient Name DOB

Signature of Patient/Representative Date