Patient Information

Texas Foot and Ankle Institute

PATIENT NAME (First Name, Middle Initial, Last Name) PATIENT ID (Office Use Only)		SECOND PHONE (WORK)	THIRD PHONE (MOBILE)
ADDRESS DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
CITY, STATE, ZIP AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER	OCCUPATION	PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS			
PRIMARY CARE DOCTOR NAME & ADDRESS			
RACE	ETHNICITY		

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)			
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		SEX (M or F)	PATIENT'S RELATION TO RES
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

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 named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient / Parent / Guardian _____ Printed Name _____ Date _____

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

Signature of Patient / Parent / Guardian / Insured _____ Printed Name _____ Date _____

PODIATRY NEW PATIENT FORM

Texas Foot & Ankle Institute, P.A., Saldino Prosthetics & Orthotics, P.L.L.C.
4104 Richmond Meadows, Texarkana, TX 75503 * Phone# (903)838-3668, Fax# (903)838-8094

Name: _____ Date of Birth: _____ Social Security #: _____
First Middle Initial Last

Physical Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip: _____

Please describe your problem (include date of injury if applicable): _____

_____

Personal Medical History

Check all that apply

If you've never had any personal medical history listed below, please check the box at the right. ☐ No Personal Medical History to report

Major Disease:
___ Diabetes
___ Hypertension (high blood pressure)
___ Heart Disease
___ Heart Attack
___ Arrhythmia
___ Stroke
___ Mini Strokes/TIA
___ Chest Pain
___ Congestive Heart Failure

Vascular:
___ Anemia
___ Bleeding Disorder/Sickle Cell
___ Diagnosed Poor Circulation
___ Blood Clots, (Location_____)

Respiratory/Lung:
___ Asthma (requiring medication)
___ Bronchitis
___ Tuberculosis
___ Emphysema

Miscellaneous:
___ Epilepsy/Seizures
___ Hepatitis/Liver Disease
___ Cancer History (Location_____)
___ Venereal Disease
___ Prostate Problems
___ Dialysis
___ Kidney Disease
___ Thyroid Disease

___ Gout
___ Arthritis

Psychological:
___ Anxiety
___ Depression
___ Dementia
___ Alzheimer's
___ Impaired Memory
___ Psychiatric Conditions _____
___ Drug Dependence History
___ Alcohol Dependence History

Head/Eyes/Ears/Nose/Throat:
___ Migraine & Headaches
___ Hard of Hearing
___ Glaucoma

Gastrointestinal:
___ Stomach Problems
___ Bowel Disorder
___ Acid Reflux (GERD)

Recent Health Review

Please **circle** any symptoms you have had in the **past 3 months**

If you have never had any Symptoms listed below, please check the box at the right. ☐ No Recent Symptoms to report

General	Fever	Chills	Fatigue	Weight Loss	Weight Gain
Head	Headaches	Visual Problems	Hearing Problems	Light Sensitivity	
Cardiovascular	Chest Pain	Palpitations	Dizziness	Swelling of Legs	Other
Hematology	Anemia	Abnormal Bleeding/bruising	Blood clots	Other blood disorder	
Respiratory	Persistent Cough	Wheezing	Shortness of Breath		
Gastrointestinal	Difficulty Swallowing	Indigestion/Heartburn	Abdominal Pain	Change in Bowel Habits	
Urinary	Painful Urination	Frequent Nighttime Urination	Bladder Leakage	Other	
Musculoskeletal	Joint Pain/Swelling/Stiffness	Back Pain	Arthritis	Muscle Weakness	
Skin	Skin Rash	Suspicious Lesions	Itching		
Neurological	Numbness of hands/feet	Seizures	Tremors	Paralysis	
Psychiatric	Depression	Anxiety	Problem Sleeping	Memory Loss	
Endocrine	Heat/Cold Intolerance	Hot Flashes	Change in hair/skin texture	Other	

Family Medical History

Has any family member had any of the following (Please indicate relationship)

Example: Mother, Father, Brother, Sister, Grandmother or Grandfather

Cancer: _____ Diabetes: _____ Heart Trouble: _____

Stroke: _____ Kidney Disease: _____ Arthritis: _____

Blood Clots: _____ Tuberculosis: _____ Emphysema: _____

High Blood Pressure: _____ Mental or Emotional Disease: _____

Surgeries

Please list all major surgeries with estimated dates and the Doctor who performed the surgery.

If you have never had any major surgeries please check the box at the right. ☐ No surgeries to report

_____

_____

Social History

Drink Alcohol: ☐ Currently ☐ In the past ☐ Never How much and how often? _____

Use Tobacco Products: ☐ Currently ☐ In the past ☐ Never How much? _____

Substance abuse: ☐ Currently ☐ In the past ☐ Never What substance? _____

Medical Allergies

If you have no know medical allergies, please check the box at the right ☐ No known allergies to report

1. Medication: _____ 2. Medication: _____

Medications

If you are not currently taking any medications, please check the box at the right ☐ No medications to report

* If you have too many to write you MUST provide a list before being seen. A current medication list is required. _____

_____

_____

Other Patient Information

Height: _____ Weight: _____ Shoe Size: _____ Occupation: _____

Exercise: Type, duration, frequency (example: Walking 30 minutes 3 x/week) _____

_____

Preferred Pharmacy: _____ Pharmacy Location: _____

I, _____, understand the Texas Foot & Ankle Institute and the office staff is authorized by me to disclose my Protected Health Information to the people that I have listed below.

1. _____ - relationship to you _____
2. _____ - relationship to you _____

I acknowledge that I have received Michael C. Saldino/Texas Foot & Ankle Institute/Saldino Prosthetics & Orthotics Notice of Health Information Privacy Rights Initials - _____

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

X Patient Signature: _____ X Date: _____