Angelo Podiatry Associates, P.A.

CONFIDENTIAL PATIENT INFORMATION

P A T I E N T I N F O R M A T I O N

TODAY'S DATE: / / **PRIMARY PHYSICIAN:**

LAST NAME: **FIRST:** **MIDDLE:** ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. **BIRTH DATE:** / / **AGE:**

ETHNICITY: ❑ White / Caucasian ❑ African American ❑ Hispanic ❑ Other: _____

MARITAL STATUS: (CIRCLE ONE) Single / Married / Divorced / Separated / Widow

SEX: ❑ M ❑ F

SOCIAL SECURITY: - - **MAILING ADDRESS:**

CITY: **STATE:** **ZIP CODE:** **HOME NUMBER:** ( ) - **CELL NUMBER:** ( ) -

OCCUPATION: **EMPLOYER:** **WORK NUMBER:** ( ) - Ext:

REFERRED BY: (PLEASE CHECK ONE) ❑ Not Applicable ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home / work ❑ Yellow Pages ❑ Other

PHARMACY: **LOCATION:** **APPOINTMENT REMINDER BY TEXT?** ❑ YES ❑ NO

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INSURANCE INFORMATION

Is this patient covered by insurance? ❑ YES ❑ NO **(PRIVATE PAY)**

PRIMARY INSURANCE: ❑ Cardholder Information Same as Above

Cardholder's Name (if different):	CARDHOLDER'S SSN:	DOB: / /	PATIENT RELATIONSHIP TO CARDHOLDER: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____
POLICY #:	GROUP #:		COPAY:

SECONDARY INSURANCE: ❑ Cardholder Information Same as Above

Cardholder's Name (if different):	CARDHOLDER'S SSN:	DOB: / /	PATIENT RELATIONSHIP TO CARDHOLDER: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____
POLICY #:	GROUP #:		COPAY:

M E D I C A L I N F O R M A T I O N

HEIGHT:

WEIGHT:

Are you allergic to any medications? ❑ YES ❑ NO

❑ Penicillin ❑ Codeine ❑ Sulfa ❑ Morphine ❑ Iodine ❑ Local Anesthetic

❑Other: _____

Do you smoke? ❑ YES ❑ NO

If yes, how much: _____

Do you drink? ❑ YES ❑ NO

If yes, how much: _____

Please check "Yes" or "No" if you are being treated for any of these conditions:

Anemia:	❑ YES	❑ NO	Kidney Disease:	❑ YES	❑ NO
Asthma:	❑ YES	❑ NO	Poor Circulation:	❑ YES	❑ NO
Arthritis:	❑ YES	❑ NO	High Cholesterol:	❑ YES	❑ NO
Cancer:	❑ YES	❑ NO	High Blood Pressure:	❑ YES	❑ NO
Hepatitis:	❑ YES	❑ NO	Diabetes:	❑ YES	❑ NO
Heart Trouble:	❑ YES	❑ NO	Insulin:	❑ YES	❑ NO
Other:	❑ YES	❑ NO	_____		

Please indicate immediate blood relatives with the following:

Arthritis: _____

Cancer: _____

Diabetes: _____

Heart Disease: _____

_____

Stroke: _____

Reason for your visit:

How long have you had symptoms?

If injury, what is the date it occurred?

Do you take any medications? ❑ YES ❑ NO

If yes, please list name and dosage: _____

_____

_____

I, the undersigned, acknowledge the above information is complete and correct to the best of my knowledge. I have reviewed the office insurance policy.

PATIENT / GUARDIAN SIGNATURE: X_____

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

AUTHORIZATION OF TREATMENT

I, the undersigned, hereby authorize Jim D. Lummus DPM / Angelo Podiatry Associates, P.A. to render treatment and/or therapy to myself that he deems medically necessary in order to treat the condition and or conditions I have requested from himself and his staff. I, the undersigned, acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices. The Notice of Privacy Practices explains how your protected health information may be used and disclosed by your physician, or our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you.

PATIENT NAME (PRINTED): _____

PATIENT SIGNATURE: **X** _____

IF PATIENT IS A MINOR:

GUARDIAN NAME (PRINTED): _____

GUARDIAN SIGNATURE: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY: ____-____-____

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly to Jim D. Lummus DPM / Angelo Podiatry Associates, P.A. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 30 days from the date of insurance payment and/or denial and if outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

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. I have read and fully understand this agreement.

X _____ _____

PATIENT / GUARDIAN SIGNATURE **DATE**