Town Center Foot & Ankle

STEPHEN G. EICHELSDORFER, DPM

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH. PLEASE FILL THIS FORM OUT COMPLETELY

PLEASE PROVIDE US WITH COPIES OF INSURANCE CARDS (both sides)

NAME OF PATIENT_____ SOCIAL SECURITY#_____

STREET_____ SEX: M F AGE_____ BIRTHDATE_____

CITY_____STATE_____ZIP_____ MARITAL STATUS: S M D W

HOME PHONE_____EMPLOYER_____PHONE_____

CELL PHONE_____ E-MAIL_____

PREFERRED CONTACT METHOD FOR APPOINTMENT REMINDERS (Circle one) Call Text Email

RACE (Circle one) American Indian or Alaska Native Asian African American Native Hawaiian or other Pacific Islander White

ETHNICITY (Circle one) Hispanic or Latino Not Hispanic or Latino PREFERRED LANGUAGE English Spanish

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

STREET_____CITY_____STATE_____ZIP_____

EMPLOYER_____STREET_____

CITY_____STATE_____ZIP_____PHONE_____

RELATIONSHIP TO PATIENT_____BIRTHDATE_____

PRIMARY CARE DOCTOR _____ PHONE_____ DATE LAST SEEN _____

EMERGENCY CONTACT_____ PHONE_____ RELATIONSHIP_____

PRIMARY INSURANCE INFORMATION

NAME OF COMPANY_____

NAME OF PERSON INSURED_____

POLICY #_____GROUP #_____

INSURED'S EMPLOYER_____

INSURED'S BIRTHDATE_____

SECONDARY INSURANCE INFORMATION

NAME OF COMPANY_____

NAME OF PERSON INSURED_____

POLICY #_____GROUP #_____

INSURED'S EMPLOYER_____

INSURED'S BIRTHDATE_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES THAT I RECEIVE. PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

SIGNATURE_____**DATE**_____

FOR PATIENTS WITH INSURANCE COVERAGE, PLEASE READ AND SIGN:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION AND REQUEST THAT BENEFITS BE PAID DIRECTLY TO DR. STEPHEN G. EICHELSDORFER FOR SERVICES RENDERED. I UNDERSTAND THAT DR. EICHELSDORFER IS FILING MY CLAIM AS A COURTESY AND THAT THIS DOES NOT RELIEVE ME OF FINANCIAL RESPONSIBILITY OF NON-COVERED SERVICES OR SUPPLIES.

SIGNATURE_____**DATE**_____

The highest compliment our patients can give is the referral of their friends and family.
Thank you for your trust!

OFFICE POLICY

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about our policies, please discuss them with our staff members. Initial each section indicating your understanding of the policy.

_____ (Initial) **HEALTH INSURANCE**

We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit to your insurance company and will only collect your co-pay or deductible when it applies. We estimate your financial responsibility using allowed amounts provided by your insurance company. Any balance remaining after the claim is processed that is deemed patient responsibility by your insurance company is your responsibility to pay. **Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit.**

If you have insurance coverage with a plan that we do not have a prior agreement with, the charges for your care and treatment are due at the time of services. In the event your health plan determines a service to be "non-covered," you will be responsible for the complete charge.

_____ (Initial) **REFERRALS**

It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

_____ (Initial) **DISABILITY/INSURANCE FORMS/COPY OF X-RAYS**

There is a $10.00 per form charge to fill out disability and insurance forms. Please mail or leave them at the front desk along with your payment. Forms will not be completed until payment is received. Please allow 5 working days for completion. We will call you once we have completed your request to arrange for you to pick them up. There is a $10.00 fee for copying digital x-rays. Please allow 2 business days for completion.

_____ (Initial) **MEDICATIONS**

Medication lists are obtained from your pharmacy to ensure we have a current and complete view of your medication history. Refills for medication prescribed by your doctor should be obtained by calling your pharmacy. Please do not call the office. Refills are not approved after normal business hours, weekends, or holidays, so please call in your refill request in time for the pharmacy to contact our office.

_____ (Initial) **CANCELLATION POLICY**

Our office will make every effort to confirm your scheduled appointment, but it is ultimately your responsibility to cancel or reschedule when necessary. **APPOINTMENTS MUST BE CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME OR THERE WILL BE A $50.00 CHARGE TO THE PATIENT'S ACCOUNT**.

I have read and understand the office policies and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ Signature

_____ Printed Name

_____ Date

Updated: 06/08/2020

Town Center Foot & Ankle

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices and that I have read or I have had the opportunity to read the Notice and understood the notice.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Town Center Foot & Ankle to discuss and/or release my protected health information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MESSAGES

Town Center Foot & Ankle may leave messages on my phone regarding my medical care: YES NO

The Texas Patient Solicitation Act requires each Texas physician, including the physicians of Town Center Foot & Ankle, to disclose information regarding ownership interest in health care facilities to which the physician may refer to his or her patients. Our physicians may or may not directly or indirectly hold equity interest in:

- Memorial Hermann Northeast Hospital
- Memorial Hermann Specialty Hospital Kingwood
- Vascular Institute of Houston
- Kingwood Medical Center
- Townsen Memorial Surgery Center
- Alliance MRI

_____ _____ _____ _____

Patient Name (Please Print) Date of Birth Signature Date

_____ _____ _____

Authorized Guardian (Please Print) Authorized Guardian Signature Date

MEDICAL INFORMATION

Name: _____ **DOB:** _____ **Date:** _____

It is a pleasure to welcome you to our office. This information is important for our records and your health.

CHIEF COMPLAINT

What is your main foot problem today? (Please be specific)

_____

_____

_____

List any other foot problems that need attention: _____

List any past problems with your feet or ankles: _____

Do you wear custom insoles (orthotics)? Yes No

What type of shoe gear do you wear most often?

Heels Flats Dress Shoes Sandals Boots Tennis Shoes

Shoe Size _____ Width _____

MEDICAL HISTORY

Check ( ) any of the following **YOU** have, or have had a problem with:

( ) Diabetes	Last HbA1c _____		Last Blood Sugar _____
( ) Lungs	( ) Asthma	( ) Heart	( ) Liver
( ) Stomach Ulcer	( ) Stroke	( ) Kidneys	( ) High Blood Pressure
( ) Thyroid	( ) Phlebitis	( ) Arthritis	( ) Gout
( ) High Cholesterol	( ) Anxiety	( ) ADD/ADHD	( ) T.B.
( ) Murmur	( ) Depression	( ) Epilepsy	( ) Eczema
( ) Bladder	( ) AIDS/HIV	( ) Skin	( ) Anemia
( ) Circulation	( ) Cancer (Type) _____		

Other: _____

Your Height _____ Weight _____ **Office Use Only** BP _____ P _____

For Women: Are you pregnant or breast feeding? Yes No

MEDICATIONS Pharmacy Name: _____ Phone: _____

Address: _____

What medications are you currently taking? (List names and dosages)

_____

_____

_____

_____

_____

MEDICAL INFORMATION

Name: _____ **DOB:** _____ **Date:** _____

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

Specialty Physician Type: _____ Name: _____ Phone: _____

Type: _____ Name: _____ Phone: _____

ALLERGIES

Check ( ) any of the following you are allergic or sensitive to and the type of reaction:

( ) Penicillin _____ ( ) Morphine _____ ( ) Tape _____
( ) Sulfa Drugs _____ ( ) Novocaine _____ ( ) Aspirin _____
( ) Betadine _____ ( ) Iodine _____ ( ) Codeine _____
( ) Neosporin _____ ( ) Latex _____ Are gloves ok? Yes No
( ) Other: _____

TRAUMATIC HISTORY AND/OR HOSPITALIZATIONS

List any serious injuries and/or hospitalizations and the year:

Injury/Illness _____ Year _____ Injury/Illness _____ Year _____

SURGERIES

List all surgeries and the year:

Surgery _____ Year _____ Surgery _____ Year _____

Surgery _____ Year _____ Surgery _____ Year _____

Surgery _____ Year _____ Surgery _____ Year _____

FAMILY HISTORY

Check ( ) if there is a **FAMILY** history of any of these disorders:

( ) Diabetes ( ) High Blood Pressure ( ) Foot Problems
( ) Heart Disease ( ) Cancer ( ) Other: _____

SOCIAL HISTORY

Your occupation: _____

Physical activity required at work: _____ Shoe gear requirements at work: _____

Do you use tobacco? Yes No Amount used per day _____ # of years _____

Type: ( ) Cigarettes ( ) Cigars ( ) Pipe ( ) Chewing Tobacco ( ) Dipping Tobacco ( ) Electronic Cigarettes

Previously used tobacco products? Yes No Type: _____

Amount per day _____ # of years _____ Year Quit _____

Do you drink alcohol? Yes No ( ) 1-2 per week/or less ( ) 1-2 per day ( ) More than 2 daily

Do you use recreational (illegal) drugs? Yes No

Are you involved in a sport or exercise program? Yes No