**Practice:** **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: _____

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## 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:** **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.MANTZOROS/DR.CASPERSON/DR.MUKKER/DR.BARCLAY**

# Patients Responsibilities and Rights

## Your Responsibilities:

☐ Follow your Physicians instructions.

☐ Be on time for your appointment. If you are more than 15 minutes late you may have to reschedule your appointment.

☐ Let us know if your address, phone numbers or insurance have changed.

☐ Carry your insurance card and photo ID with you at all times and bring to every appointment that you have. This is required to be seen.

☐ Co-payments and other payments are due at time of service.

☐ Know all of your insurance benefits.

☐ It is the responsibility of the patient to get/provide a referral to our office is one is required.

☐ **Allow 48-72 hours for all prescription refills.**

☐ Please respect fellow patients and our office staff.

☐ If you are unable to keep an appointment please give the office atlease 24 hours' notice. We may charge $20 for any un-kept appointments.

## Your Rights:

☐ Receive quality health care.

☐ Be involved in decisions regarding the medical care you receive.

☐ Receive assistance from your insurance company's customer service for concerns and questions.

☐ 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.MANTZOROS/DR.CASPERSON/DR.MUKKER/DR.BARCLAY

## Office and Financial Policies

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

Initials:_____ **Insurance: The patient is responsible for knowing their insurance benefits and if you have a deductible or copayment.** If you have an **HMO** policy you must change your PCP to one of our doctors in the facility. If it is not changed prior to the appointment you may be asked to reschedule or will be responsible for all services done that day. We will gladly file your insurance claim on your behalf. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials:_____ **Cancellations/No Show:** Please call our office 24 hours in advance if you are unable to keep a scheduled appointment. If you do not call in the allowed time frame we may charge a fee of $20.

Initials:_____ **Referrals:** Patients with an **HMO** policy need referrals to see any specialist. It is the patients' responsibility to provide/acquire a referral before you have scheduled an appointment.

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. Please also bring your insurance card with you to **every** appointment. Without the insurance card we will be unable to file your insurance and you will be responsible for the charges for the day. On follow-up appointments you will be asked to verify demographic and insurance information so our records remain up to date. Your copay is due at time of check in.

Initials:_____ **Check-out:** Please be prepared to pay for the current visit as well as any past balances on your account. Deductibles, percentages or fees for non-covered services will be required at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____ **Late arrivals:** We do our best to keep to the schedule. When a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes late you may be asked to reschedule your appointment so that other patients are not inconvenienced.

Initials:_____ **Dishonored checks:** A $30 service fee will be assessed on all dishonored checks. The full amount of the check written plus $30 must be paid by cash or credit card. If payment is not received within 10-15 business days your information will be filed with the Montgomery 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 be able to accept a check from you.

Initials:_____ **Collections:** You will be receiving at least 3 statements from our office for balances owed. Please ensure to make payment arrangements, if necessary, to keep your account current. If your address changes it is your responsibility to inform our office to update our records, otherwise, your account will be turned over to collections when it is returned as a bad address. When your account is already in collections, you **may not** be seen until the account is paid in full at the collection agency.

Initials:_____ **Prescriptions:** It is the patients responsibility to call the pharmacy 5 days prior to running out of medication.
***Refills may take between 2 - 4 business days to be refilled.**

Initials:_____ **Prior Authorization:** A $25 fee will be due for any prior authorization that is needed on any medications.

Initials:_____ **Disability/FMLA papers:** A $25 fee will be charged for forms completed by provider per fill out session.

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

_____

Print Patient Name DOB

_____

Signature of Patient/Representative Date

**DR.MANTZOROS/DR.CASPERSON/DR.MUKKER/DR.BARCLAY**

# Authorization to Release Health Care Information

Patient's Name: _____ Date of Birth: _____

It is ok to release any information about my medical records and health concerns to the following persons that I have listed (**EXAMPLE: spouse, parent, children, friends …**) This does not include other doctor offices.

Name _____ Relationship_____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship_____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Is it ok to leave a detailed message on your voicemail YES NO

I understand that my signed consent is required to release any and all healthcare information relating to testing, diagnosis, and/or treatment for sexually transmitted diseases, psychiatric disorders, or mental health disorders.

**This authorization expires one year from the date signed**

_____

Print Patient Name DOB

_____

Signature of Patient/Representative Date

**DR.MANTZOROS/DR.CASPERSON/DR.MUKKER/DR.BARCLAY**

# Acknowledgement/Notice of Privacy Practices

I have been provided a copy to review of 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 if requested.

**Notice:**

The physicians Conroe Foot Specialists, Huntsville Podiatry Associates, and/or Woodlands Foot Specialists, (Dr. Dimitrios Mantzoros, Dr. Timothy Casperson, Dr. Gurpreet Mukker, Dr. Gene Barclay) may or may not have financial interest in the following facilities: Conroe Surgery Center, Aspire Hospital Outpatient Radiology LLP, Premier Pharmacy, and/or The Woodlands Vascular Access Center.

_____

Print Patient Name DOB

_____

Signature of Patient/Representative Date