WELCOME TO OUR PRACTICE

PATIENT INFORMATION

All information will be confidential.

We are not a Worker's Compensation Provider.
We do not file Texas Worker's Comp cases or motorcycle/motor vehicle accident claims.

Patient Name _____ Age: _____
Last, First, Middle

Social Security # _____ - _____ - _____ Date of Birth: _____

Gender: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____

Work Phone # _____ Email: _____

Employer_____ Position_____

Primary insured's name if other than patient _____ D.O.B. _____

Pharmacy: _____ Location: _____

Who is Your Primary Care Doctor? _____

Whom may we thank for referring you? (Please Mark Appropriate Box Below)

Insurance Plan☐ Friend/Family☐ Doctor☐_____ Phone Book☐ Previous patient☐

Google☐ Yelp☐ Facebook☐ Other_____

EmergencyContact:_____D.O.B._____

Relationship: _____ Phone: _____

To the best of my knowledge, the questions on the forms have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____ _____
Signature of Patient, Parent or Guardian D.O.B. Date

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

- As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.
- **We are NOT a worker's compensation insurance provider. We do not file Worker's Comp cases or motorcycle/motor vehicle accident claims.** I understand that I am responsible for any charges owed to this office due to my care at the time of service.
- **Is this a work related or a vehicle accident injury?** ☐ **Yes** ☐ **No**
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CASH AND CHECKS.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill the insurers/health plans that we have an agreement with, but we require you to pay the copay, deductible and coinsurance at the time of service for your treatment.
- If you have insurance coverage with a plan that we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services; however, you remain responsible for charges to any service rendered.
- You must inform the office of all insurance changes, authorization and referral requirements. In the event the office is not informed, you will be responsible for any charges denied by your insurance.
- There are certain elective surgical procedures that require pre-payment. You will be informed in advance if your procedure is one of those. Payment will be due two days prior to the surgery.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Name _____ DOB _____ Date _____
Last, First

What is your specific foot/ankle problem? _____

Current Prescription Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies

☐ Yes ☐ No Penicillin
☐ Yes ☐ No Aspirin
☐ Yes ☐ No Codeine
☐ Yes ☐ No Adhesive Tape
☐ Yes ☐ No Sulfa
☐ Yes ☐ No Local Anesthetic
☐ Yes ☐ No Other _____

Past Medical History

Diabetes # years _____	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Aids or HIV	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Tendency to form large scars	☐ Yes ☐ No
Arthritis: Type _____	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Artificial Joints: Where? _____	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Bleeding Problems	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No		

Any other disease (please list) _____

Previous Surgeries

1. _____
2. _____
3. _____

Social History

Occupation _____
Tobacco: ☐Never ☐Current ☐Past Quit Date _____
Alcohol: ☐Never ☐Social ☐Daily

Height _____ Weight _____

Have You Experienced Any of These Symptoms Recently?

General		**Endocrine**	
General good health lately	☐ Yes ☐ No	Excessive thirst or urination	☐ Yes ☐ No
Fever/Chills	☐ Yes ☐ No	**Musculoskeletal**	
Respiratory		Joint pain/stiffness	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Muscle pain/cramps	☐ Yes ☐ No
Past anesthesia difficulties	☐ Yes ☐ No	**Integumentary**	
Cardiovascular		Rash or itching	☐ Yes ☐ No
Palpitations/Arrythmias	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	**Neurological**	
Swelling of feet or ankles	☐ Yes ☐ No	Tremors	☐ Yes ☐ No
Gastrointestinal		Numbness/Tingling	☐ Yes ☐ No
Stomach ulcers	☐ Yes ☐ No	**Hematologic/Lymphatic**	
Reflux	☐ Yes ☐ No	Bleeding tendency	☐ Yes ☐ No
Intolerance to Aspirin/NSAIDS	☐ Yes ☐ No	Past transfusion	☐ Yes ☐ No

ALL INSURED PATIENTS

I request that payment of authorized insurance benefits be made to Steven B. Beito, DPM, J. Jacob Ransom, DPM or New Braunfels Podiatry, for any services furnished to me by that physician. I authorize any holder of medical information about me at New Braunfels Podiatry to release said information to the insurance entity requesting it.

Patient's Signature_____ Date_____

I have read a copy of the New Braunfels Podiatry Associates, LLC Notice of Privacy Practices.

Patient/Guardian Signature _____Date _____

I wish the following individual(s) to have access to my medical information:

_____D.O.B_____

Staff Will Fill out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notices of Privacy Practices, but it could not be obtained for the following reason:

____ Patient refused to sign.

____ Emergency situations kept us from obtaining the patient's signature.

____ Language barriers kept us from obtaining the patient's signature.

____ Other _____