Vivian Abrams, DPM / Dennis G. Shaw, DPM

4201 Medical Center Drive, Suite 290, McKinney, TX 75069

Welcome to our office. Please take a few minutes to fill out this form completely. When you are finished, please bring it, your insurance card and your driver's license to the front window.

Patient Information

Patient's Legal Name _____

Name you go by _____

Home Address _____

City/State _____ **Zip** _____

Home Phone _____ **Cell:** _____

Sex: o **M** o **F** o Single o Married o Widowed o Separated o Divorced

Age _____ **Birth date** _____ **Weight** _____ **Height** _____ **Shoe Size** _____

All patients complete this section. If the patient is a minor, complete this section with the parents' information.

Employer _____ Occupation _____

Business address _____

City _____ State _____ Zip _____ Phone _____

Spouse's Name _____

Spouse's Employer _____ Occupation _____

Business address _____

City _____ State _____ Zip _____ Phone _____

Referral information - How did you find out about this office? I am an existing patient _____

Phone book Word of mouth Insurance Sign Internet

Doctor _____ Another patient _____ Other _____

Family Physician _____ Last visit date _____

Emergency contact (nearest friend / relative not living with you)

Name _____ Phone _____

INSURANCE INFORMATION - If your insurance is in a name other than the patient, please complete this section.

Insured Name _____ *Insured Date of Birth* _____

Insured Employer _____

What is your chief complaint today? _____

Have you ever been to a podiatrist before? o Yes o No Name _____

Last Visit Date _____

See Next Page

Allergies

Have you ever had an allergic reaction to any of the following? **o NONE**

o	Advil	o	Erythromycin	o	Morphine
o	Aleve	o	Ibuprofen	o	Penicillin
o	Aspirin	o	Iodine / Betadine	o	Sulfa
o	Codeine	o	IVP Iodine	o	Tape
o	Demerol	o	Local anesthetics	o	Tylenol

o Any other medication _____

Family History

Are there any members of your immediate family (mother, father, brother, sister, child) who have had any of the following?

o None	o Unknown		
o Arthritis	o Diabetes	o Heart attack	o Stroke
o Cancer	o Foot problems	o High blood pressure	o Other _____

MEDICATIONS o NONE o SEE LIST (Please bring list to front desk.)

Are you currently taking any medications, including herbal remedies or vitamins? If yes, please list below.

_____ _____

_____ _____

_____ _____

_____ _____

Medical History

Please circle if you have had any of the below problems o **None of these**

AIDS / HIV
Alzheimer's disease
Anemia
Angina / Chest pain
Arthritis / osteo or rheumatoid
Asthma
Back problems or pain
Blood disorders
Cancer
Chronic diarrhea
Circulatory problems
Diabetes
Ear problems
Eye problems
Fainting / syncope
Foot / leg cramps
Gout
Headaches
Heart disease
Hepatitis or Jaundice
High blood pressure
Kidney problems
Low blood pressure
Mental health problems
type _____
Mitral valve prolapse
Nerve damage
Osteoporosis
Parkinson's Disease
Phlebitis / blood clots
Seizure disorder / epilepsy
Shortness of breath
Sinus problems
Stomach ulcers
Stroke / TIA's / mini-strokes
Swelling in ankles or feet
Thyroid
Tuberculosis
Unexplained weight loss
Varicose Veins

Other _____

Hospitalization and Surgical History

Hospitalizations, reason and approximate date o **None**

_____

_____

Surgeries with approximate date o **None**

_____

_____

_____

Social History

Do you drink alcohol beverages? None Social Mild Moderate Heavy Quit When?_____

Do you use recreational drugs? None Social Mild Moderate Heavy Quit When? _____

Do you have a sexually transmitted disease? o No o Yes

Do you smoke, use tobacco products i.e.Vaping, E-Cigarettes o No o Yes How many packs a day?_____

_____

Are you slow to heal after cuts? o No o Yes

Do you have abnormal bruising, bleeding or scarring? o No o Yes

_____

Females:

Are you currently pregnant? o No o Yes Last menstrual period _____

_____

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and or treatment of my feet. This must be signed to be seen by the doctor.

_____ _____

Signature *Date*

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SIGNATURE ON FILE

I authorize

- use of this form on all my insurance submissions
- release of information to all my insurance companies, laboratories and radiology facilities used for my treatment
- my doctor to act as my agent in helping me obtain payment from my insurance company/companies
- payment direct to my doctor
- a copy of this authorization to be used in place of the original

I understand I am responsible for my bill.
I understand that this authorization remains in effect until revoked in writing.

Signature _____ Date _____
(Patient / responsible party)

FOR MEDICARE PATIENTS ONLY

Due to Medicare guidelines, we are obligated to accept assignment on covered services some of which are listed below. I understand I am responsible for non-covered services (examples listed below) at the time the service is rendered.

Covered Services

Foot care on patients who are Diabetic or have
Peripheral Vascular Disease
also taking oral medication
meeting Medicare's "class findings" and
being treated by a physician within 6 months
X-rays
Surgery-such as bunions, hammertoes and ingrown nails
Fracture
Infection

Non-Covered Services

Routine cutting of nails and
trimming calluses and corns
Foot supports / Orthotics
Padding / Strapping
Supplies

Signature _____ Date _____
(Patient / responsible party)

NOTICE OF PRIVACY PRACTICES AND GENERAL CONSENT

Vivian Abrams, DPM / Dennis G. Shaw, DPM

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so choose) and understood the Notice. It is located in the waiting room in the magazine rack.

You may leave any of the following information blank if you object to giving us the information.

Should you want to change, add or omit this information at any time, contact us.

However, you MUST complete the following if <u>any information</u> is to be given.

1. If we may inform a family member or other persons about your medical condition and your diagnosis, please print their name and relationship to you.

_____

_____

2. Please print a phone number, if other than your home phone, where you want to receive calls regarding information for appointments, diagnoses or other health information.

_____

3. Can we leave confidential messages on your home phone answering machine or voice mail?
Or, if you gave us another phone number to call, can we do the same on that phone number?

YES _____ NO _____

4. If you do not have an answering machine or voice mail, can a confidential message be left at your place of employment?

YES _____ NO _____

5. Can we send a postcard to remind you of appointments that are greater than 6 weeks away? YES _____ NO _____

Patient Name _____ Signature _____ Date _____

If patient is unable to sign,
Guardian Signature _____ *Date* _____
Relationship to patient _____