

# Associates in Foot Surgery

C.E. Singleton, DPM  
6900 Denton Highway, Suite 111  
Watauga, TX 76148

## Welcome to Our Office

### Personal Information

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
Occupation \_\_\_\_\_ SSN \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

### Insured Information

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
SSN \_\_\_\_\_ Birth Date \_\_\_\_\_ Employer \_\_\_\_\_

### Form of Payment

Check  Cash  MasterCard/Visa

Whom may we thank for referring you to our office?

### Authorization and Release

Permission is given to Dr. C.E. Singleton and Associates to render the proposed podiatric examination and treatment. I agree that I am responsible for any payment for services rendered by the doctor. I also authorize the release of my medical records for insurance purposes only.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## Health Questionnaire

If you have any questions about the information we are requesting, please ask

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

Name and address of Primary Care Physician \_\_\_\_\_

Date of last visit \_\_\_\_\_

Reason \_\_\_\_\_

Have you been hospitalized in the past 2 years?  Yes  No

Surgical History: List most recent and approximate year:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications currently taking: please list all

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Please check or fill in the blanks:

Unusual or allergic reactions to the following medications: (nausea, rash, rapid heart beat, etc)

Yes No

- Penicillin  
  Other antibiotics  
Local anesthetics \_\_\_\_\_  
Barbiturates, sedatives \_\_\_\_\_  
  Sleeping pills  
  Codeine   
Other \_\_\_\_\_

Yes No

- Sulfa  
  Iodine  
  Adhesive tape  
  Tetanus  
Anti-inflammatory \_\_\_\_\_  
  Demerol

### Medical History

Have you ever had:

- |                          |                          |                                    |                          |                          |                  |
|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                           | <input type="checkbox"/> | <input type="checkbox"/> | Lung disease     |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart ailment                      | <input type="checkbox"/> | <input type="checkbox"/> | Tumors/cancer    |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                | <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory disorder               | <input type="checkbox"/> | <input type="checkbox"/> | AIDS             |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever                    | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                             | <input type="checkbox"/> | <input type="checkbox"/> | Gout             |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                          | <input type="checkbox"/> | <input type="checkbox"/> | Phlebitis        |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney/bladder disease             | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins   |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease                      | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer/colitis    |
| <input type="checkbox"/> | <input type="checkbox"/> | Injury to feet, ankles, legs, back |                          |                          |                  |

## Family History

Yes No

- Are you, to the best of your knowledge, pregnant?
- Gained/lost weight recently (more than 20 pounds)
- Family history of diabetes
- Family history of gout
- Family history of arthritis
- Family history of bunions or other foot disorders
- Are you excessively nervous regularly?
- Do you have a tendency to get dizzy or faint?
- Do you now or have you ever smoked?
- If yes, number of packs per day \_\_\_\_\_ How long since you quit \_\_\_\_\_
- Do you drink?
- Occasionally  Socially  Frequently
- Do you bruise easily?
- Do you bleed for a long time when you cut yourself?
- Do you form thick or excessive scars? Where? \_\_\_\_\_

## Leg and Foot History

- Do you limit your activities because your feet hurt?
- Do your feet or ankles swell regularly?
- If yes, are you taking water pills? \_\_\_\_\_
- Do you have cramping in your legs or feet?
- If yes, morning or evening? \_\_\_\_\_
- Does your job require a lot of standing/walking?
- Do you now or have you ever worn foot inlays?
- If yes, custom made? \_\_\_\_\_
- Have you ever had long term steroid therapy?
- If yes, how long \_\_\_\_\_
- Have you ever had any previous foot treatment?
- By whom \_\_\_\_\_
- What was done and when? \_\_\_\_\_
- \_\_\_\_\_

Briefly describe your foot problem:

Location: \_\_\_\_\_ How painful? Moderate severe

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Are there any other medical problems?  Yes  No

If yes, explain \_\_\_\_\_

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Your signature signifies that you have answered these questions to the best of your knowledge. All answers are considered privileged medical information and are kept confidential.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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817-656-0303

**Please read and check the part that applies to you and sign your name at the bottom. Please present your insurance card and driver's license to the front desk. Thank you.**

**Medicare Patient**

We do not accept assignment. Full payment will be due at each visit. We will submit the claim to Medicare for you and you will be reimbursed according to Medicare Guidelines. Medicare does not cover most foot care. We will not know if your visit is covered until the doctor sees you. He will evaluate your condition and determine if your condition is covered based on the rules and guidelines of Medicare, which we much adhere to.

**HMO, PPO, POS Patient**

If a referral is needed, we must have it at the time of your appointment. It is your responsibility to obtain the referral. If you do not have your referral at the time of your appointment, you may do one of two things: reschedule the appointment or you may pay the bill in full. We suggest that you call our office a day or two before your appointment to be sure we have received your referral. All co-payments shall be paid at the time of your visit. You may be required to pay your bill in full if deductibles are part of your plan.

If your referral states a specific problem, the doctor is only allowed to treat that problem. Any other problems will require another referral. These are not our rules, but the rules of your plan.

**No Insurance or 3<sup>rd</sup> Party Insurance**

Payment in full is due at the time the service is rendered. A receipt will be given to you to file your own insurance. If a surgical procedure is needed, we will file your insurance if the charge is more than \$250 and benefits can be verified before services are rendered. If you have no insurance, please discuss any financial problems you have with the Office Manager before you see the doctor.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## Patient Questionnaire

**Patient Name** \_\_\_\_\_

Please list the family members or other persons, if any, whom we may inform about your general condition and your diagnosis:

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Please list the family members or other persons, if any, whom we may inform about you medical condition **only in an emergency**:

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Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address:

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Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"

Yes     No

Please print the telephone number, if any, where you want to receive calls about your appointments, lab or x-ray results or other health care information, if other than your home telephone number:

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Can confidential messages (appointment reminders) be left on your home answering machine or voicemail?

Yes     No

Your place of employment?

Yes     No

May we contact your pharmacy by phone for prescriptions?

Yes     No

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date

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**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I was offered a copy of the Notice of Privacy Practices.

I request/do not request a copy of the Privacy Practices.

Patient Name (please print) \_\_\_\_\_

Date \_\_\_\_\_

Patient or authorized representative (if applicable) \_\_\_\_\_

Signature \_\_\_\_\_