TEXAS FOOT & ANKLE CENTER
A Division of Podiatric Medical Partners of Texas, P.A.

Matthew S. Babich, DPM
Gary A. Heredia, DPM
Paul Kinberg, DPM
1151 N. Buckner Blvd Ste #201
Dallas, TX 75218
o: 214-660-077 f: 877-631-1566
e: office@txfac.com

WELCOME TO TEXAS FOOT & ANKLE CENTER
PATIENT INFORMATION
(This confidential information is important so we can learn about your health)

Name:_____ Date:_____
LAST FIRST MI

Date of Birth (DOB): _____ Age: _____ Sex: _____

Race: _____ Ethnicity:_____ Primary Language:_____

Driver's License #:_____ Social Security #:_____

Home Phone: _____ Mobile #: _____

Email: _____

Home Address: _____
STREET CITY STATE ZIP

INSURANCE INFORMATION
Primary Medical Insurance: _____

ID/Member #: _____ Group/Policy #: _____

Secondary Insurance: _____

ID/Member #: _____ Group/Policy #: _____

RESPONSIBLE PARTY (SELF / NAME OF PERSON INSURANCE IS CARRIED BY OR PRIMARY CARRIER OF THE INSURANCE)

Name of Insured (if other than patient): _____

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

Employed by: _____Work Phone: _____

Address if different from patient: _____

EMPLOYMENT: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Student

Employed By: _____ Work Phone: _____ Ext: _____

Work Address: _____

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Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse (Parent) Name: _____ Spouse (Parent) DOB: _____

Spouse (Parent) Occupation: _____ Spouse (Parent) Phone #: _____

REFERRED BY: ☐ *Doctor:* _____ ☐ *Patient/Friend:* _____
☐ *Insurance* ☐ *Online Search* ☐ *Social Media (Facebook, Google Reviews, Yelp, etc.)*

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____ Home phone: _____

Address: _____
STREET CITY STATE ZIP

Cell #: _____ Work #: _____ Ext_____

PREFERRED PHARMACY INFORMATION:

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____
STREET CITY STATE ZIP

I hereby give my permission to Dr. Matthew Babich, DPM; Gary Heredia, DPM; and/or Paul Kinberg, DPM; his associates or assistants to examine and administer treatment as may be deemed necessary during the care of my condition. I understand that I am financially responsible for all charges, whether or not paid by insurance. The only limitation to my financial liability for charges not paid by insurance occurs In the event of contractual limitations to the charged fees that have been agreed upon by Texas Foot & Ankle Center (Comfort Podiatry) and the insurance company.

_____ _____
Signature Date

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MEDICAL INFORMATION

What is your foot/ankle problem?_____

_____

Duration? _____ days; _____ weeks; _____ months; _____ years. R or L Foot? _____

Any prior treatment? _____ By Whom? _____

Primary Physician: _____ DATE OF LAST EXAM: _____

Former Podiatrist: _____

Have you had any other problems with your feet or ankles? _____

Have you had any operations (surgery) on your feet or ankles? _____

GENERAL HEALTH INFORMATION:

Weight: _____ Height: _____ Current Shoe Size/Width: _____ Type of shoe normally worn: _____

Do you have diabetes? ☐ Yes ☐ No. If yes, do you take insulin? ☐ Yes ☐ No. Number of Years _____

Do you or did you smoke, dip or chew tobacco? ☐ Yes; ☐ No.

If yes, number of packs/cigars per day: _____ Number of years: _____ If you quit using tobacco, how long ago? _____

Do you drink beer, wine or alcohol? ☐Yes; ☐ No. If yes, ☐ occasional; ☐ moderate; ☐ heavy.

Do you drink beverages with caffeine? ☐ Yes; ☐ No. ☐coffee; ☐ tea; ☐ soft drinks

At your job, do you: ☐ sit most of the time; ☐ stand most of the time; ☐ stand and walk.

Does your employer require you to wear certain shoes at work? ☐ Yes; ☐ No.

If yes, are the shoes: ☐ boots with steel toes; ☐ dress [men] / fashion shoes (high heels) [women]

Please list all medications you take: _____

_____

_____

_____

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Please check ☑ if you have ALLERGIES (REACTIONS) to:

- ☐ Penicillin
- ☐ Sulfa
- ☐ Iodine (Betadine or dye)
- ☐ Keflex
- ☐ Tetracycline
- ☐ Darvon / Darvocet
- ☐ Erythromycin
- ☐ Aspirin
- ☐ Anti-inflammatory (Naprosyn, Advil, Motrin, Aleve, et)
- ☐ Codeine
- ☐ Morphine or Demerol
- ☐ Local anesthesia
- ☐ Adhesive tape; Band-aids
- ☐ Other(s):

_____
_____
_____
_____

Do you have any artificial joint(s) or heart valve: ☐ Yes; ☐ No. If yes, where: _____

Please check ☑ if you have a problem with any of the following:

- ☐ Frequent fainting
- ☐ Dizziness
- ☐ Migraine(s)
- ☐ Weight loss
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Teeth or gum problems
- ☐ Blood transfusion(s)
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Mitral valve problems
- ☐ Obstructive pulmonary disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ AIDS / HIV / ARC
- ☐ Rheumatic Fever
- ☐ Gastric reflux
- ☐ Getting up to urinate after going to bed
- ☐ Urinary incontinence
- ☐ Hemorrhoids
- ☐ Prostate problems (male)
- ☐ Yeast infections (female)
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Chronic low back pain
- ☐ Stiffness
- ☐ Thick scar or keloid formation
- ☐ Skin rash or scaling skin
- ☐ Skin cancer
- ☐ Tattoo(s)
- ☐ Numbness or burning in arms, hands, legs or feet
- ☐ Tingling in arms, hands, legs or feet
- ☐ Memory loss
- ☐ Depression
- ☐ Panic attacks
- ☐ Obsessive-compulsive disorder
- ☐ Menopause (female)
- ☐ Sickle cell disease or trait
- ☐ Anemia
- ☐ Gout
- ☐ Frequent infections
- ☐ Asthma
- ☐ Other cancer(s):

_____
_____
_____
_____

FAMILY HISTORY:

Mother: ☐ Living; ☐ Deceased; Cause of death: _____
Father: ☐ Living; ☐ Deceased; Cause of death: _____
Brother: ☐ Living; ☐ Deceased; Cause of death: _____
Sister: ☐ Living; ☐ Deceased; Cause of death: _____

Please check ☑ if there is a family member (blood relative) history of:

- ☐ Arthritis
- ☐ Heart disease
- ☐ Bleeding disorders
- ☐ Sickle Cell
- ☐ Diabetes
- ☐ Gout
- ☐ Flat feet
- ☐ Bunions
- ☐ Hammertoes
- ☐ Neurologic disorders

_____ _____
Signature Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and I understand the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent's Name or Name of Authorized Representative (if applicable)

_____
Signature

☐ I hereby give my permission to Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM to disclose and discuss any information related to my medical condition(s) to / with the following family member(s), other relatives and / or close personal friends:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition.

_____ _____
Signature Date

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LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL RECORDS AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I,

_____

the undersigned have insurance and/or employee health care benefits coverage with the enclosed caption, and hereby assign and convey directly to Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM; all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the above named podiatrist. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payment and understand that these balances are due within ninety (90) days from the date of insurance payment and/or denial and if outside attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM to release all medical information to process my claims. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM any and all plan documents, insurance policy and/or settlement information upon written request from Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize use of this signature on all my insurance and/or employee health benefit claim submissions.

I hereby convey to Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM to the full extent possible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or health care plan with respect to medical expenses incurred as a result of the medical services I received from Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM in any attempts by Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bringing suit with Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM against such insurers and/or employee health care plan in my name, but at Dr. Matthew Babich, DPM; Gary Heredia, DPM; Paul Kinberg, DPM expense.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

Relationship of Guardian to Minor Child: _____

_____
Witness

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PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, Texas Foot & Ankle Center now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

Texas Foot & Ankle Center believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from Texas Foot & Ankle Center via e-mail or text messaging.

Texas Foot & Ankle Center does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company or with any other patient.

Please print all information neatly and legibly.

_____
Name

_____
E-mail Address

_____
Cell Phone Number

☐ Yes, please sign me up to receive e-mail and text messaging confirmations.

☐ I do NOT wish to be contacted via e-mail. *(Text Messaging ONLY)*

☐ I do NOT wish to be contacted via text messaging. *(E-mail ONLY)*

☐ I do NOT wish to be contacted by either text messaging or email.