



Matthew S. Babich, DPM
Gary A. Heredia, DPM
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A Division of Podiatric Medical Partners of Texas, P.A.

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 _____

Have you had any serious illness or have you had any surgery? Yes; No. If yes, what: _____

Are you currently under the care of any other physician? Yes; No. If yes, for what problem(s)? _____

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, what kind? _____

Please list all medications you take: _____



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Please check if you have ALLERGIES (REACTIONS) to:

- | | | |
|---|---|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Adhesive tape; Band-aids |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Anti-inflammatory
(Naprosyn, Advil, Motrin,
Aleve, et) | <input type="checkbox"/> Other(s):
_____ |
| <input type="checkbox"/> Iodine (Betadine or dye) | <input type="checkbox"/> Codeine | _____ |
| <input type="checkbox"/> Keflex | <input type="checkbox"/> Morphine or Demerol | _____ |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Local anesthesia | _____ |
| <input type="checkbox"/> Darvon / Darvocet | | |
| <input type="checkbox"/> Erythromycin | | |

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:

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

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:

- | | | | |
|---|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Flat feet | <input type="checkbox"/> Neurologic
disorders |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bunions | |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Hammertoes | |

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 **BOTH EMAIL** and **TEXT MESSAGING** confirmations.

OR

YES, please sign me up to receive, **TEXT MESSAGING ONLY**. I do **NOT** wish to be contacted via e-mail.

OR

YES, please sign me up to receive **E-MAIL ONLY**. I do **NOT** wish to be contacted via text messaging.

OR

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