PATIENT INFORMATION

Please Print

Name ____ Date of Birth ______/_____/________
First Middle Last

Sex Male ___ Female ___ Married ___ Single ___ Widowed ___ Divorced/Separated ___

Home Address __________________________________ Apt No _______ SS# _____________
Number Street

City _____________________________ State ________ Zip __________________________

Home Phone ______________ Work Phone ____________ Email Address _________________

Patient Occupation _________________________ Employer _____________________________

Employer Phone __________________________

If patient is a child or dependent adult, please give name of responsible party for finances and billing

Responsible Party ________________________________ Date of Birth ______/____/__________

Responsible Party Employer ________________________ Phone __________________________

Insurance Information

( ) Check here if NO health insurance

Primary Carrier ___________________________ Policy Holder Name _____________________
(If other than patient)

Policy Holder SS# ______________________ Group # ______________ ID # ___________

Relationship to insured Self _____ Spouse _____ Child ______

Secondary Carrier ________________________ Policy Holder Name _____________________
(If other than patient)

Policy Holder SS# ______________________ Group # _____________ ID # ___________

Relationship to insured Self _____ Spouse _____ Child ______

Were you referred to this office? By Whom? ____

Referring Doctor _______________________________________ Phone _____________________

How did you hear about our office? ____

Is this a compensation or work-related case? Yes ____ No ____ Date of Accident ___________

Briefly describe foot problem ____

Signature ____________________________________ Date ______________________________

Driver's License Number _______________________ Relationship to Patient _______________

Past Medical History

Today's Date______________

Name ____ Sex _____ Date of Birth _____/____/_____

Age _________ Height ___________ Weight ___________ Shoe Size ___________

Occupation ____

Chief Complaint ____

____

Onset: Sudden _____ Gradual ______ Previous Fractures/Dislocations __________________

Current Health Good ______ Fair ______ Poor ______

Currently Seeking Medical Care Yes ______ No ______ Why ____________________________

____

( ) Diabetes
( ) Circulatory Disease
( ) Bleeding Disorders
( ) Rheumatic Fever
( ) Stomach Ulcers
( ) HIV
( ) Seizure Disorders
( ) Hypertension (High B/P)
( ) Hypotension (Low B/P)
( ) Nervous Condition
( ) Sickle Cell Anemia
( ) Pregnant
( ) Heart Trouble
( ) Kidney Trouble
( ) Liver Disease
( ) Hepatitis
( ) Skin Problems
( ) Arthritis
( ) Asthma
( ) Epilepsy
( ) Stroke
( ) Gout

Other ________________________________

Allergies:

( ) Foods
( ) Aspirin
( ) Codeine
( ) Penicillin
( ) Sulphites
( ) Sulphur
( ) Local Anesthesia
( ) Novocain
( ) Iodine
( ) Tape
( ) Other:

____

____

____

Past Surgical History:

Surgery	**Date**	**Surgery**	**Date**
____________________	_____________	____________________	________________
____________________	_____________	____________________	________________
____________________	_____________	____________________	________________

Present Medications

Medications	**Illness**	**Medications**	**Illness**
____________________	_____________	____________________	________________
____________________	_____________	____________________	________________
____________________	_____________	____________________	________________

Family History: ( ) Diabetes ( ) Hypertension ( ) Bleeding Disorder ( ) Circulatory
( ) Arthritis ( ) Problem with Anesthesia

Social History: Tobacco (Pks/Day) _______ Coffee/Tea (Cups) _______ Alcohol _______

Do you take aspirin regularly? _______ Do you faint easily? __________

INSURANCE AUTHORIZATION/PAYMENT POLICY

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance company(ies), and assign directly to Dr. Mantzoros/Dr. Barclay/Dr. Casperson/Dr. Mukker all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions:

____ Date ________________________________

Responsible Party Signature

Medicare Authorization (If Applicable)

I request that payment of Medicare benefits be made on my behalf to Dr. Mantzoros/Dr. Barclay/Dr. Casperson/Dr. Mukker for any services furnished me by that physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the carrier.

____ Date ________________________________

Payment Policies

All copays, deductibles, and coinsurance are due at the time of service. If you belong to an HMO, you will need a referral. If you belong to a PPO, you may have a deductible. Remember, it is your responsibility as a patient to get a referral if one is required. If you do not have one, you will be responsible for out-of-network benefits. Please let the receptionist know if you have new insurance at your time of arrival.

Insurance Release/Authorization

I understand that for medical/legal purposes and by Texas State Law, X-rays and medical records taken/created by this office are the property of Dr. Mantzoros, Dr. Barclay, Dr. Casperson, and Dr. Mukker. I also understand that all charges for services are due and payable at the time the services are rendered. We accept cash, checks, Mastercard, Visa and Discover.

I agree to be responsible for the charges on this account.

______________________________________ Date _______________________________

Patient or Guardian

CONROE FOOT SPECIALIST
D. S. MANTZOROS, D.P.M.
G. BARCLAY, D.P.M.
T. C. CASPERSON, D.P.M.
G. K. MUKKER, D.P.M.

DATE______________________________

I, __________________________________, herby authorize the staff of Dr. Mantzoros, Dr. Barclay, Dr. Casperson, and Dr. Mukker, to disclose information to the following person(s) about my procedures, as well as any other information concerning my health. I also authorize the following person(s) to receive information concerning my financial statement.

Name	Relationship	Date	Initial
1. ___________________	______________	___________	____
2. ___________________	______________	___________	____
3. ___________________	______________	___________	____
4. ___________________	______________	___________	____
5. ___________________	______________	___________	____

PLEASE NOTE:

There will be times this office will call and leave messages regarding appointments and/or procedures.

This will be effective until I, _________________________, put in writing that I withdraw the above listed person(s).

___________________________________ ____________________
Signature Date