Trinity Foot Center Lisa J. Brandy D.P.M. | 1801 N. Hampton Road Ste. 340 Desoto, TX 75115 * Phone: 972-293-9650 * Fax: 972-291-2533

## PATIENT INFORMATION

Full Name _____

DOB _____/_____/_____ Age_____ ☐ Male ☐ Female

Address _____

City/State/Zip _____

Cell Phone _____ Home Phone_____

**Which you prefer to be called on first: ( ) Cell ( ) Home**

Email _____

**Ethnicity:** ☐ NOT Hispanic or Latino ☐ Hispanic or Latino ☐ Decline

**Primary language:** ☐ English ☐ Spanish ☐ Other _____

**Race:** ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Black or African American ☐ American Indian ☐ Decline

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

Employer _____Occupation_____

HOW DID YOU HEAR ABOUT US?

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Friend | ☐ Google | ☐ Doctor Referral | ☐ Yelp | ☐ Insurance | ☐ Internet | ☐ Other_____ |

Family physician:_____Phone#_____ Last seen:_____

Doctor who treats your Diabetes (if diabetic) : _____ Last seen: _____

Emergency Contact _____Phone _____Relationship:_____

Pharmacy _____ Address _____ City_____

Consent for our office to download your medication list from online through a pharmacy manager, if available? Yes ___ No ___

**My Preferred method of communication in regards to my medical condition**

1.) How can we contact you? (check ALL that apply) ☐ Phone ☐ Mail ☐ Email ☐Text message

2.) **Do you consent for our office to leave a detailed message?** ☐ Yes ☐ No

3.) Whom may we release medical information to: _____

## INSURANCE INFORMATION:

| **PRIMARY Insurance Name** | **Member ID #:** |
|---|---|
| Policy Holder Name & Birthday | **DOB:** / / |
| Policy Holder Employer | |

| **SECONDARY Ins. Name** | **Member ID #:** |
|---|---|
| Policy Holder Name & Birthday | **DOB:** / / |

**Notification of Changes**

If/when any of the above information, (i.e. name, phone number, insurance,) changes, I will provide the updated information promptly.

**X**_____**DATE**_____

**Patient's Signature or Parent/ Legal Guardian**

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# MEDICAL HISTORY

**PATIENT NAME: _____**

**State in your own words your medical reason(s) for coming into our office:**

_____

_____

**Is this visit related to an injury at work? (___) Yes (___) No**

| | |
|---|---|
| **Shoe Size: _____** | **Are you a current smoker? Yes No** |
| **Height: _____ Weight: _____** | **If no, Are you a former smoker? Yes No** |

**FOR WOMEN ONLY**: ARE YOU PREGNANT? _____IF SO HOW MANY MONTHS? _____
Or ARE YOU BREAST FEEDING? _____

**MEDICATIONS- Please list all medications that you currently use:**

_____

_____

_____

**ALLERGIES**- Are you **allergic** to or have you ever reacted to any of the following?:

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | Aspirin | Yes | No | Lidocaine (local anesthesia) |
| Yes | No | Band-aids/ tape | Yes | No | Sulfa drugs |
| Yes | No | Latex | Yes | No | Penicillin |
| Yes | No | Steroids | O**ther:** _____ | | |

**List Past Surgeries:** _____

**YOUR Past Medical History**: Have **YOU** ever **HAD or HAVE** any of the following? **CHECK ALL THAT APPLY**

**ENTM:** (__) Trouble Hearing
(__) Wears Hearing Aids
**Musculoskeletal:** (__) Arthritis
(__) Gout
**Neurological:** (__) Cramping (legs or feet)
(__) Numbness (legs or feet)
(__) Tingling (legs or feet)
(__) Burning (legs or feet)
(__) Shooting Pain
**CVS:** (__) Chest Pain
(__) Heart Disease
(__) Shortness of Breath
(__) Ankle Swelling
(__) High Blood Pressure
(__) Kidney disease
(__) Stroke

**GI:** (__) Stomach Ulcers
(__) GERD
(__) Acid Reflux
**Endocrine:** (__) Diabetes
(__) Thyroid disorder
(__) Anemia
**Psychiatry:** (__) Anxiety
(__) Alzheimer's
(__) Dementia
(__) Depression
**Social:** (__) Alcoholism
(__) Drug Abuse
**Immunology:** (__) Cancer
(__)HIV/AIDS

**(___) NONE OF THE ABOVE**

**FAMILY Past Medical History:** Circle **ALL** that apply

| | | | | | | |
|---|---|---|---|---|---|---|
| **Father:** | Diabetes | Kidney Disease | Hypertension | Cancer | None | Unknown |
| **Mother:** | Diabetes | Kidney Disease | Hypertension | Cancer | None | Unknown |

X_____ _____
Patient's Signature or Parent/ Legal Guardian Date

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# OFFICE POLICIES

**PATIENT NAME**:_____

## Authorization to Treat and for Insurance to Pay

I give Trinity Foot Center permission to give me medical treatment. I understand I have the right to refuse any procedure or treatment and the right to discuss all medical treatments with my clinician. I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Trinity Foot Center, PC, the office of Lisa J. Brandy, DPM. I hereby agree to promptly pay for any service(s) provided to me not covered by my insurance policy. I agree to pay all co-payments, deductibles, coinsurance, and products sold through Trinity Foot Center, PC. I authorize the above named provider to release to the Social Security Administration or its intermediaries any information needed for the claim or related medical claim. I further permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for the charges not covered by my insurance program. Benefits provided by your insurance company are not a guarantee of payment.

## Non-Covered Services

It is important to understand that some of the services provided to you may not be covered under your current insurance plan. Therefore, it is important that you check with your insurance company to verify your benefits. You will be responsible for full payment of any services not covered by your insurance at the time of your visit.

## Products and DME Supplies

All over-the-counter products purchased are non-refundable. All durable medical equipment (DME) such as ankle/foot braces, shoes, and walking boots, etc. are non-refundable once dispensed.

## Surgery

Some minor surgical procedures are performed in our office. Most insurance carriers put these in the category of “surgery”, meaning that the procedure may be applied to a surgical deductible or coinsurance. Therefore, you may be billed for an amount over and above the usual visit co-payment at your visit. If the procedure is not covered by your insurance, we will require 100% payment at the time of the surgery.

## Appointments

It is our goal to provide services to you in the most comfortable and timely manner possible. In order to achieve this, we ask that you be on time for your appointments. We realize your time is valuable and we endeavor to keep on schedule, while providing each patient with personalized care. However, emergencies do occur, and may cause delays in our schedule. We will try to keep you informed of these delays should they arise. **If you must cancel an appointment, we ask that you kindly notify us at least 24 hours in advance. There is a $25 fee for each no show occurrence.**

## Prescriptions

Please allow 24 hours for new prescriptions, refills, or medication change requests to be processed and sent to your pharmacy. Please contact your pharmacy for refills so that a written request can be faxed to our office. No prescription refill or change requests will be handled after regular office hours or on the weekend.

## Notice of Privacy Practices

Our office follows all HIPAA and Privacy Practice Acts as required by law. The privacy practice notice is posted in our lobby. Upon request, you will be provided a copy in paper or electronic form. I have read (or had the opportunity to read if I so chose) and understood the notice.

Thank you for choosing us for your foot care needs. If you have any questions regarding these policies, please notify a member of our business office during regular hours. We will do our best to ensure your understanding of our policies so that we may concentrate on you and your care. I acknowledge that I have read and understand the contents of the financial and office policies for Trinity Foot Center, PC.

X_____Date_____

Patient’s Signature or Parent/ Legal Guardian