

PATIENT INFORMATION AND HISTORY

In order that we may better understand problems you may be having with your feet or legs, we must first know something about your health to general. Please answer as many of the following questions as possible. Thank you for your cooperation.

NAME: First _____ Middle _____ Last _____

DATE OF BIRTH: _____ AGE: _____ SEX: Male/Female HEIGHT: _____ WEIGHT: _____

HOW DID YOU FIND US? ER referral Family Doctor Referral Insurance Directory Phonebook

Family Friend Current Patient Plano Profile Walk-in Internet

WHAT BRINGS YOU TO SEE US TODAY? _____

NAME AND PHONE NUMBER OF PRIMARY CARE DOCTOR: _____

MEDICATIONS: What medications (and dosage) are you taking? _____

ALLERGIES: circle and give reaction you had.

Iodine _____ Penicillin _____ Pain Medication _____ Aspirin _____

General Anesthetics _____ Local Anesthetics _____ Adhesive tape _____

Sulfa Drugs _____ Environmental Allergies _____ Food Allergies _____

Tell us anything not listed above that you are allergic to and your reaction. _____

PAST MEDICAL HISTORY: If you now have or have ever had any of the following conditions, please circle:

Anemia	Children/Pregnancies	Headaches	Phlebitis
Anxiety	Circulation problems	Hearing problems	Rheumatism
Arthritis	Depression	Heart Attack(s)	Skin problems
Asthma	Diabetes	Hepatitis	Stroke
Bleeding problems	Drug/Alcohol dependency	High blood pressure	Thyroid problems
Blood Clots	Eye disease	High Cholesterol	Ulcers
Blood Transfusion(s)	GastroIntestinal disorders	HIV/AID	Urinary disorders
Bowel Problems	Glasses or contacts	Lupus	Venereal disease
Cancer	Gout	Neuromuscular disease	

FAMILY HISTORY (list any medical conditions that run in your family and member(s) it affects: _____

HOSPITALIZATIONS/SURGERIES: List all hospitalizations and surgeries you have had. Begin with the most recent. Give month and year. _____

SOCIAL HISTORY: circle or fill in all that apply

Married Alcohol Intake: _____ Caffeine Intakes _____ cups/days

Single Smoker: _____ pack(s)/day X _____ years Recreational drug use: _____

Divorced Retired? Yes No if retired, please tell us your previous occupation below.

Widowed Occupation: _____

Signature _____

Date _____

Address _____

City _____ State _____ Zip Code _____

SS# _____ License# _____ State _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

THE FOLLOWING SECTION MUST BE FILLED OUT FOR INSURANCE PURPOSES

Medicare: Yes _____ No _____ Medicaid: Yes _____ No _____

Primary Insurance Company _____ Policy# _____ Group# _____

Insured's Name _____ SS# _____
First Name Middle Initial Last Name

Birthdate ____/____/____ Patient's Relationship to Insured: Self Spouse Child Other

Insured's Address: Same as patient's _____ other: _____

Insured's Phone number: Same as patient's _____ other: _____

Secondary Insurance Company _____ Policy# _____ Group# _____

Insured's Name _____ SS# _____
First Name Middle Initial Last Name

Birth Date _____ Patient's Relationship to Insured: Self Spouse Child Other

Nearest Relative/Friend _____ (____) _____
First Name(s) Last Name Phone Number

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I Authorize Jill Wisdom, DPM to release and furnish on a confidential and strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality PPO's, managed care organizations, IPA's, Medicare/Medicaid or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions.

Signature of Patient/Responsible Party _____ Date _____

PLEASE GIVE US YOUR INSURANCE CARD AND PHOTO ID

PREMIER FOOT AND ANKLE
Jill C. Wisdom, DPM, PA
6309 Preston Rd., Suite 1200
Plano, TX. 75024
(972) 769-7280

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment (copays and supplies), unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility. I understand that filing a claim with my insurance does not relieve me from my responsibility for the payment of charges. I acknowledge that payment or payment arrangements are expected at the time a statement is received.

Signature of Patient, Parent, Guardian or Personal Representative

Printed name of Patient, Parent, Guardian or Personal Representative

This paper is to serve as notification that Dr. Wisdom is an investor in the following businesses:

Up and Open MRI
Surgery Center of Plano
Surgery Center of Craig Ranch
Summit Physical Therapy

Signature of Patient