

**MID COUNTY FOOT AND ANKLE  
2234 NEDERLAND AVE.  
PORT NECHES, TX 77651**

Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Middle Last Date of Birth Age

SSN \_\_\_\_\_ Marital Status: S M W D Gender: M F

Address \_\_\_\_\_  
Street City State Zip

Cell Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

**EMAIL ADDRESS (THIS IS MANDATORY FOR BILLING)** \_\_\_\_\_

Reminder Preference: Email Voicemail Text

Primary Provider \_\_\_\_\_  
Name Phone

Pharmacy \_\_\_\_\_  
Name City/Phone

Emergency Contact \_\_\_\_\_  
Name Phone  
Relationship to patient \_\_\_\_\_

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**INSURANCE INFORMATION**

Primary Insurance Name \_\_\_\_\_ Policy ID/No. \_\_\_\_\_ Group No. \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_ Policy ID/No. \_\_\_\_\_ Group No. \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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**Reason for visit:** \_\_\_\_\_

I hereby authorize payment directly to Mid County Foot and Ankle for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the provider and this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all submissions.

**Signature of Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

**PAST MEDICAL HISTORY**

**HEAD**

Trauma

**EYES**

Blindness  
 Cataracts  
 Glaucoma  
 Wears Glasses/Contacts

**CARDIOVASCULAR**

Aneurysm  
 Angina  
 DVT  
 Hypertension (BP)  
 Myocardial Infarction  
 Other Heart Disease

**RESPIRATORY**

Asthma  
 Bronchitis  
 COPD/Emphysema

**GASTROINTESTINAL**

Cirrhosis  
 GERD  
 Gallbladder Disease  
 Heartburn  
 Hepatitis  
 Ulcer (stomach)

**GENITOURINARY**

Hernia  
 STDs  
 UTIs  
 other kidney disease

**MUSCULOSKELETAL**

Arthritis  
 Gout  
 M/S injury

**SKIN**

Dermatitis  
 Mole(s)  
 Psoriasis  
 other skin condition(s)

**NEUROLOGICAL**

Stroke  
 TIA

**PSYCHIATRIC**

Bipolar disorder  
 Depression

**ENDOCRINE**

Hyperlipidemia  
 Hypothyroidism  
 Thyroid Disease  
 Thyroiditis  
 Type 1 Diabetes  
 Type 2 Diabetes

**HEME/ONCOLOGY**

Anemia  
 Cancer

**INFECTIONS**

HIV  
 STDs

**OTHER:** \_\_\_\_\_

**SURGICAL HISTORY**

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Cholecystectomy/Gallbladder	<input type="checkbox"/> Spinal Fusion
<input type="checkbox"/> Bariatric SX/Gastic Bypass	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> TURP
<input type="checkbox"/> CABG	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Other
<input type="checkbox"/> Carotid Endarterectomy/Stent	<input type="checkbox"/> Tonsillectomy/Adenoids	_____

**FAMILY HISTORY**

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> CAD	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Mental Illness	

**SOCIAL HISTORY**

<b>TOBACCO</b>	<b>ALCOHOL</b>	<b>DRUG ABUSE</b>	<b>SEXUAL ACTIVITY</b>
<input type="checkbox"/> Current daily smoker	<input type="checkbox"/> Do Not Drink	<input type="checkbox"/> IV drug use	<input type="checkbox"/> Exposure to STI/STD
<input type="checkbox"/> Current occasional smoker	<input type="checkbox"/> Drink daily	<input type="checkbox"/> Illicit drug use	
<input type="checkbox"/> Former smoker	<input type="checkbox"/> Drink frequently	<input type="checkbox"/> No illicit drug use	
<input type="checkbox"/> Never smoked	<input type="checkbox"/> Drink occasionally		

Are you pregnant: Yes No      Any abnormal bruising: Yes No      Do you have any vascular grafts: Yes No

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

**CONSENT**

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature of Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

*(A copy or list of allergies and current medications may be given to our staff at check-in)*

Drug Allergies:

No Known Drug Allergies: \_\_\_\_\_


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**CURRENT MEDICATIONS**

**(please include dosage)**


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Patient/Guardian Signature

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Date

## Consent for Disclosure of Protected Health Information

With this consent, representatives of Mid County Foot and Ankle may call or mail my home or other alternative location, or leave a message on voicemail in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointments, discussion of lab, radiology, or procedure results, or to ask to call regarding an issue or concern.

I authorize Mid County Foot and Ankle and his staff to release laboratory/radiology results and reports to the following individuals listed below. At no time will a representative of Mid County Foot and Ankle discuss your medical circumstances or condition without your consent.

1. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

2. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

This authorization shall be in force and effect until one year from the date of signature. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

2234 Nederland Ave.  
Port Neches, TX 77651

\_\_\_\_\_ **No, I do not wish my information to be released to anyone but myself.**

By signing this form, I acknowledge that the Notice of Privacy Practices was available and that I have read (or had the opportunity to read if I choose) and understand the notice.

By signing this form, I am consenting to allow Mid County Foot and Ankle and his office staff to use and disclose my personal health information to carry out treatment, payment, and health care operations. I also accept full financial responsibilities for any services not covered by my insurance policy/policies.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

## OFFICE AND FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office staff.

### **Health Insurance**

We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with the insurance company and will only collect your copay, deductible, and/or coinsurance when it applies. **Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit.**

If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service.

### **Patient Payments**

In the event your health plan determines a service to be “non-covered”, you will be responsible for the complete charge. Payment is due upon receipt of statement from this office unless prior arrangements have been made. I understand that there will be a \$35.00 NSF fee for any returned checks.

### **Referrals**

It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

### **Disability and Insurance Forms**

There is a \$30.00 fee to fill out disability and insurance forms. Please mail or leave them at the front desk along with your payment. Forms will not be completed until payment is received. **Please allow at least 5 business working days for processing.** We will contact you once we have completed your request.

### **Release and Obtain Medical History**

I hereby authorize Mid County Foot and Ankle to receive and release any medical or surgical information necessary for the treatment of my medical or surgical conditions and in order to process any and all insurance claims on my behalf.

### **Medical History Authority**

I grant Mid County Foot and Ankle the authority to download my medication history automatically from Surescripts. This medication history may include prescriptions from all of my treating physicians within the last 12-month period.

I have read and understand the office policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. I hereby assign my insurance benefits to be paid directly Mid County Foot and Ankle.

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Signature of Patient or Responsible Party

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Date

## **NO-SHOW POLICY MID COUNTY FOOT AND ANKLE**

We understand that circumstances can cause you to miss an appointment. However, if you do not contact our office prior to the appointment, a charge will be placed on your account. Please contact our office within 24 hours of your scheduled appointment or as soon as you are aware you will miss the appointment.

Also, all appointment times are important. Therefore, missed appointments leave time that other patients could have been seen for important treatments. Please be considerate of our office and other patients by being on time for your appointment. If you know that you will be more than 20 minutes late, please contact our office so we can determine if you can still be seen. If you are more than 20 minutes late without notification, we reserve the right to place a charge on your account.

Please note that our office always works with patients in all unplanned circumstances to be seen as soon as possible after a missed appointment. The care of his patients is very important to him.

We appreciate your attention to this request.

**NO SHOW CHARGES: \$30.00**

**LATE CHARGES:           \$30.00**

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**Patient Name**

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**Patient/Responsible Party Signature**

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**Date**