SOUTHWEST FOOT & ANKLE CENTER

Plano Office: 5804 Coit Rd. #100, Plano, Texas 75023
Plano Office: 972-424-3505
Lewisville Office: 502 N. Valley Pkwy #2, Lewisville, Texas 75067
Irving Office: 6161 N State Hwy 161 Ste. #320, Irving, Texas 75038
Lewisville/Irving Office: 972-316-0902
Fax: 972-316-1161

DFW Wound Care Center

PATIENT INFORMATION

Please fill out the following confidential form for our records:

Patient Name: (As it apprears on insurance card)	
(first) (middle) (last)	
Todays Date:	**Age:** (MM/DD/YEAR)
Home #:	**Cell #:**
Work #:	**Ext:**
Address:	
Email:	
Social Security #:	**Sex:** ( ) Male ( ) Female
Emergancy Name Contact:	**Telephone #:** **Cell #:**
Pharmacy Name/Address:	**Phone #:**
Referring source: ( ) advertisement, specify_____ ( ) family/friend ( ) Insurance ( ) Newspaper ( ) ZocDoc ( ) Phone Book ( ) Google ( ) Yelp ( ) Internet ( ) Other, *specify*:	

PATIENT EMPLOYER INFORMATION

***Patient* Employer Name:** (indicate n/a if minor)	
Address:	
Patient Occupation:	
Conatact Person (at work):	**Phone #:** **Fax # :**
1- If today's visit is due to an injury at work- plase *check* ( ) Yes ( ) No	
2- Have you notified your persoannel depatment? Plase *check* ( ) Yes ( ) No	
Please give brief description of injury *(mm/year):*	

POLICY HOLDER (GUARANTOR) INFORAMTION

Policy Holder's Name: (As it apprears on insurance card)	
(first) (middle) (last)	
Address: (if different than patient):	
SS #:	**Age:** (MM/DD/YEAR)
Home #:	**Cell #:**
Work #:	**Sex:** ( ) Male ( ) Female
Employer Name:	**Employer Address:**
Email:	

SURGERIES & HOSPITALIZATIONS: *circle* all that apply (describe procedure, mm/year and any complications):

None	Appendectomy	C-Section
Angioplasty	Bypass	Cataracts
Cholecystectomy	Other:	
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? If **Yes** please describe (mm/year) & surgeon:		
Do you have any artificial Joints: **circle** Yes/No, if yes where:		
Do you have an artificial hear valve? c*ircle* Yes/No		

SOCIAL HISTORY:

Occupation:		Do you Smoke? c*ircle* Yes/No If yes how many packs per day:	
Do you drink Alcohol? c*ircle* Yes/No, if yes indicate How many per day_____ Per week _____ per Month _____			
Illicit drugs? c*ircle* Yes/No, if yes what kind _____ how much_____ per day, _____ per week, & for how long _____ please *specify*: Have you had a substance abuse past? Circle Yes/No- if yes please *specify*:			
Do you exercise regularly? c*ircle* which one applies:			
No, never	Yes, 1-2 times per week for at least 30 minutes	Yes, 3-5 times per week for at least 30 minutes	Yes, 5-6 times per week for at least 30 minutes
Would you like more information on exerise and healthy diet? Yes/No			

FAMILY HISTORY: please *circle* if there are any family history (blood relative) that has the following, please indicate who:

Alzheimer's	Who:	Depression/Anxiety	Who:
Arthritis	Who:	Diabetes (type 1 or 2)	Who:
Bleeding disorders	Who:	Emphysema	Who:
Blood Clot	Who:	Heart disease	Who:
Cancer (what kind)	Who:	High Blood Pressure	Who:
Cataracts	Who:	Neurological	Who:
Circulations Problems	Who:	Strokes	Who:
Other (*specify*):		Addiction (*Specify*)	Who:

PHYSICIAN INFORMAITON:

Primary Physician: circle Yes/No if you would like your results sent to them:	
Name:	Address:
Telephone Number:	Fax Number:

PATIENT EMPLOYER INFORMATION

Patient **Employer Name:** (indicate n/a if minor)	
Address: _____ *Street* *City* *State* *Zip Code*	
Patient Occupation:	
Conatact Person (at work):	**Phone #:** **Fax # :**
1- If today's visit is due to an injury at work- plase *check* ( ) Yes ( ) No	
2- Have you notified your persoannel depatment? Plase *check* ( ) Yes ( ) No	
Please give brief description of injury *(mm/year):*	

POLICY HOLDER (GUARANTOR) INFORAMTION

Policy Holder's Name: (As it apprears on insurance card)	
Address: (if different than patient):	
SS #:	**Age:** (MM/DD/YEAR)
Home #:	**Cell #**:
Work #:	**Sex**: ( ) Male ( ) Female
Employer Name:	**Employer Address**:
Email:	

INSURANCE INFORMATION

No Insurance Self Pay (circle here) Yes/No	
Primary Insurance Co. Name:	**ID/Member #:**
Group Name:	Group #:
Effective Date:	Expiration Date:
Patient's relationship to Policy holder:	Policy Holders Name:
Secondary Insurance Co. Name:	**ID/Member #:**
Group Name:	Group #:
Effective Date:	Expiration Date:
Patient's relationship to Policy holder:	Policy Holders Name:

I also understand that Soutwest Foot and Ankle Center, DFW Woundcare Center or Southwest Footcare and Associates, LLP is not ultimatly responsible for collecting my insurance or negotiation settlements of claims.

Explanation of Payment Policy & Privacy Policy & Insurance Filing Procedures:

I hereby acknowledge the above information is correct to the best of my knowledge. I authorize any and all release of information obtained during my treatment to my primary care physician or referral sources. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed on patient information forms.

I authorize Southwest Foot & Ankle Center, DFW Wound Care or Southwest Footcare & Associates to release information pertinent to the filing of insurance claims for the patient names above. I authorize my insurance carriers to pay benefits directly to Southwest Foot & Ankle Center, PA on any unpaid serices filed on my behalf. I undersand that I am responsiblie for paying Southwest Foot & Ankle Center for charges that the above patient regardless of my insurance coverage. I also understand that Soutwest Foot & Ankle Center PA is not ultimatle responsible for collecting my insurance or negotiationg settlement for claims. I understand that I AM RESPONSIBLE for payment to Southwest Foot and Ankle, DFW Woundcare Centers or Southwest Footcare and Associates, PA for charges for the above patient regardless of my insurance coverage.

I acknowledge that was given a copy of Southwest Foot & Ankles notice of privacy practices and that I have had the opportunity to read and understand the notice.

I hereby give Southwest Foot & Ankle Center, DFW Wound Care or Southwest Footcare & Associates permission to diagnose and administer treatment for my foot, ankle or wound condition and authoritze any release of information obtained during my treatment.

Patient/Legal Guardian Signature:	**Date:**