

Foot & Ankle Center of North Houston, P.C.
17215 Red Oak Drive, Suite 102
Houston, Texas 77090
281-444-4114
Fax 281-444-7789
www.footanklecenter.net

Larry S. MacTavish, D.P.M. Scott E. Margolis, D.P.M. Jerry K. Miles, D.P.M.
Jason R. Armstrong, D.P.M. Turner C. Butts, D.P.M. Scott MacTavish, D.P.M.

Date _____

Patient Information

Patient Name _____ Age _____ Sex M F

Address _____ Marital Status M S W D

City _____ State _____ Zip _____ Day Phone _____

DOB _____ SSN _____ Drivers License Number _____

EMERGENCY CONTACT NUMBERS: _____

Patient Employment Information

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Phone _____ Ext. _____

Patient School Information

Full Time _____ Part Time _____ School Attending _____

Responsible (Insured) Party (if different from above)

Name _____ Relation to Patient _____

Address _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Social Security Number _____

Employer Phone Number _____ Email _____

Primary Care Physician _____ Date Last Seen _____

How Were You Referred to Our Office? _____

IT IS YOUR RESPONSIBILITY TO MAINTAIN A CURRENT REFERRAL
IN ORDER TO SEE THE PHYSICIAN LISTED ABOVE.

Medical Information

My foot problem is (please describe): _____

Length of pain/problem? _____ Shoe Size: _____

Work related? Yes No Date of Injury: _____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU NOW HAVE OR HAVE HAD PREVIOUSLY:

GOVT	EPILEPSY	CIRCULATION PROBLEMS	HIGH BLOOD PRESSURE
ANEMIA	ARTHRITIS	KIDNEY PROBLEMS	SHORTNESS OF BREATH
CANCER	ULCERS	STOMACH PROBLEMS	BLEEDING DISORDERS
ASTHMA	FAINTING	HEART TROUBLE	MUSCULAR DISORDERS
HEPATITIS	HAY FEVER	THYROID PROBLEMS	HEALING DIFFICULTY

OTHER (PLEASE SPECIFY): _____

ARE YOU DIABETIC? Y ___ N ___ INSULIN DEPENDENT? Y ___ N ___

DOCTOR SEEN FOR DIABETES: _____ DIET CONTROLLED? Y ___ N ___

PLEASE CIRCLE ANY KNOWN ALLERGIES

PENICILLIN	NOVACAINE	CODEINE	LOCAL ANESTHESIA
TAPE	IODINE	ASPIRIN	SULFA DRUGS

OTHER KNOWN ALLERGIES: _____

Do you have any METAL IMPLANTS? Y ___ N ___

SOCIAL HISTORY

ALCOHOL RECREATIONAL DRUGS SMOKER PREGNANT HIV POSITIVE

OTHER SOCIAL HABITS _____

FAMILY HISTORY

HIGH BLOOD PRESSURE CANCER TUBERCULOSIS DIABETES EMPHYSEMA
BLOOD CLOTS HEART DISEASE SICKLE CELL LIVER DISEASE KIDNEY DISEASE

THYROID PROBLEMS OTHER GENETIC DISORDERS _____

PLEASE LIST ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER) CURRENTLY TAKING (WITH DOSAGE)

PREVIOUS SURGERIES (WITH APPROXIMATE DATES)

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Insurance Information

Primary Coverage

Insured's Name _____ Employer _____ SSN _____
Insurance Company Name _____ Group ID _____
Mailing Address _____ Phone _____
City _____ State _____ Zip _____ Effective Date _____

Secondary Coverage

Insured's Name _____ Employer _____ SSN _____
Insurance Company Name _____ Group ID _____
Mailing Address _____ Phone _____
City _____ State _____ Zip _____ Effective Date _____

All Doctors at the Foot & Ankle Center of North Houston, P.C. are Participating Providers of Medicare. This means that we accept the fee Medicare approves for our services. **The patient or secondary insurance is responsible for the difference in what Medicare approves and what they pay (\$100.00 deductible/year and 20% copay at each visit).** We file all Medicare claims for our patients.

We also accept Medicaid. This also means that we accept what Medicaid allows for our services. **If Medicaid does not approve a procedure, the patient is responsible for those charges.**

We are participating providers on a number of insurance programs such as HMO's, PPO's, and POS's. This means we accept what the insurance program's determination for our services. If your insurance denies a service, the patient and/or responsible party is responsible for those charges. **We do call and verify all procedures in most cases, before any treatment is rendered, so the patient is informed in advance. At that time, you will be given the option to proceed with the prescribed treatment, make financial arrangements or decline the treatment.**

If your insurance company requires a specific form, please provide the form with your portion completed and sign at the time of service. If any of the above applies to you, please provide us with your insurance card(s) so that we can make copies for our file.

*I _____ agree to be responsible for any charges that my insurance
(Patient/Responsible Party) does not cover.

*PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments below.

Signed _____ Date _____

*INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the physician's listed here in.

Signed _____ Date _____

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize photographs to be taken of my foot or ankle disorder. Any photographs taken are property of The Foot and Ankle Center of North Houston, P.C. and may be used for teaching studies, insurance appeals, etc. Identity markings will be removed prior to reproduction.

Signed _____ Date _____