817.377.3668
www.trinityfootandankle.com

Medical Building II
5801 Oakbend Trail, Suite 140 - Fort Worth, Texas 76132

New Patient Intake Form

Please Complete All Questions - So that we may maintain the most up to date and accurate information on our patients we will request that you review and update this form at least once a year.

Date:_______________________

Patient Information
Patient Name - First:______________________________MI:______Last:______________________________

DOB:________________Age:_____Sex:____SS#:______________________________

Address:____

____

Home Phone#:_______________Cell Phone#:_______________Work Phone#:_______________
Preferred Phone # (Circle Above) Email:______________________________

Emergency Contact:______________________________Relationship to Patient______________________

Emergency Contact Phone#: ____

Parent / Legal Guardian Name if patient is a minor Name:_______________________DOB:_______________

Who referred you for this visit?____

Who is your Primary Care Physician/Family Physician?____

How did you hear about us?____

Pharmacy (utilized for ePrescriptions):______________________________ Phone#:_______________________

Address and/or Cross Street:____

Marital Status: (Single) (Married) (Divorced) (Separated) (Widowed) Children: (Yes / No, #_________)

Race/Ethnicity: (American Indian) (Asian) (Black/African American) (Native Hawaiian) (Other Pacific Islander) (White/Caucasian) (Hispanic) (Latino) (Other:______________________________)

Employment
Job Title:______________________________ Name of Employer:______________________________
(Presently Employed) (Student) (Disabled) (Retired) (Not Working) (Light Duty)

Address of Employer:______________________________ Phone#:_______________________

____

Patient Name:____________________

Responsible Financial Party:
(___Same as Patient Information - If different, please complete section below)

Name - First:____________________MI:________Last:____________________

DOB:____________________Age:______Sex:_____SS#:____________________

Address:____________________

Home Phone#:____________________Cell Phone#:____________________Work Phone#:____________________
Preferred Phone # (Circle Above) Email:____________________

Employer:____________________

Address:____________________

Insurance Information:
Please Provide a copy of all Insurance Cards and a valid Driver's License / Photo ID

Primary Insurance:____________________ ID#:____________________ Group#: ____________________

Policy Holder Name:____________________ Relationship (Circle One) Self Spouse Parent Other:____________________

DOB:____________________ SS#:____________________

Employer:____________________Phone#:____________________

Address:____________________

Secondary Insurance:____________________ ID#:____________________ Group#: ____________________

Policy Holder Name:____________________ Relationship (Circle One) Self Spouse Parent Other:____________________

DOB:____________________ SS#:____________________

Employer:____________________Phone#:____________________

Address:____________________

Privacy
Trinity Foot & Ankle Spec, PLLC, providers, and staff are committed to securing the continued privacy of your health records/information.

Telephone Authorization:
Due to Health Insurance Portability and Accountability Act (HIPPA) of 1996, The following information must be filled out for each patient annually.
I authorize Trinity Foot & Ankle Spec, PLLC to leave messages at the following telephone numbers.
Home# (Yes / No) Work# (Yes / No) Cell# (Yes / No)
Other Comments:____________________

Optional Authorization for Release of Medical Information to Others
___Do Not Release Information

I authorize Trinity Foot & Ankle Spec, PLLC and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to appointments, billing information and/or medical care. This authorization will remain in effect until I provide notification to Trinity Foot & Ankle Spec of changes or updates.

Name:____________________ Relationship:____________________ Phone#:____________________

Dr. Glen Beede Dr. Gary Driver Dr. Gregory Jaryga

Patient Name:____________________

Release of Information: I authorize the providers and staff of Trinity Foot & Ankle Spec, PLLC to: Release to any third party payor such as an insurance company or governmental agency any medical information contained in my records when such material is required in connection with determining a claim for payment. Release of any medical information accumulated in the course of my examination or treatment to any other requesting doctor, hospital or nursing home. I authorize the release of any medical information to the providers at Trinity Foot & Ankle Spec, PLLC that might be contained within any other doctor or hospital records; including x-rays, laboratory reports, or other information

Financial/Payment Guidelines: Payment is due at the time of services. This includes all co-pays, deductibles, and co-insurance. If your insurance company requires a referral, it is in the patients responsibility to obtain the referral prior to your appointment.I authorize payment to Trinity Foot & Ankle Spec, PLLC and the Providers on staff at Trinity Foot & Ankle Spec, PLLC of any group and/or individual surgical and/or medical benefits otherwise payable to . I authorize the payment as a direct assignment of my rights and benefits under my insurance policy. If my policy prohibits direct payment to Trinity Foot & Ankle Spec, PLLC, I hear-by instruct and direct my insurers to make the check payable to me and mail the check to: Trinity Foot & Ankle Spec, PLLC - 5801 Oakbend Trail #140 - Fort Worth Texas 76132. I authorize that my insurance benefits payable to Trinity Foot & Ankle Spec, PLLC will be paid by my insurers in a reasonable and timely fashion. I assign my right to Trinity Foot & Ankle Spec, PLLC to file a complaint with the State of Insurance Commissioner or with any state or federal regulatory agency that covers my insurers if payment is not made to Trinity Foot & Ankle Spec, PLLC within a reasonable time period.

Authorization of Care: I authorize the providers at Trinity Foot & Ankle Spec, PLLC to examine me and to make such tests and perform such procedures as they feel in their judgment are reasonable and necessary in the diagnosis and treatment of my case.
I acknowledge that no guarantees have been made to me in the result of treatments and examinations done by the providers at Trinity Foot & Ankle Spec, PLLC.
Lab/X-Ray/Diagnostic Services: I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.
Acknowledgment of Responsibility for Payment: I agree to pay Trinity Foot & Ankle Spec, PLLC the professional fees in return for my care. I agree that if the amount of any insurance benefits due to me is insufficient to cover the professional fees of my care that I will be responsible for the payment of the difference, including any deductibles and co-payments. If the insurance coverage is insufficient, denied, or otherwise unavailable. I agree to pay Trinity Foot & Ankle Spec, PLLC all charges not covered my by insurance. I also agree to pay all costs and expenses, including a reasonable attorney or collection agency fee incurred or paid by Trinity Foot & Ankle Spec, PLLC in the collection of this obligation by suit or others.

Original Assignments, Authorizations and Release on File: I permit a copy of the above assignments, authorizations and releases to be used in place of the original which has been filed in the office of Trinity Foot & Ankle Spec, PLLC.

Medicare Release: I request that payment of authorized Medicare benefits be made on my behalf to Trinity Foot & Ankle Spec, PLLC for any services provided/furnished to me by the providers at Trinity Foot & Ankle Spec, PLLC. I authorize Trinity Foot & Ankle Spec, PLLC to release medical information about me to the Health Care Financing Administration and its agents and any information needed to determine these benefits payable for related services.

Authorization to Treat a minor:
___Not applicable (patient is an adult)
If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization the for following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Trinity Foot & Ankle Spec, PLLC to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results are medical care to those listed below.

Name:______________________________ Relationship:____________________ Phone#:________________________

I have read, understand and agree to the above Financial responsibilities statement, Payment guidelines, consent for treatment, and release of any and all medical information and insurance authorization. I also certify that all information provided as complete and accurate to the best of my knowledge.

X______________________________ ______________________________ ____________
Signature of Patient/Parent *Relationship to Patient* *Date*

Dr. Glen Beede Dr. Gary Driver Dr. Gregory Jaryga

Patient Name:____________________

Medical Questionnaire

Describe your problem

Left / Right

Describe Your Problem:____

____

____

Where is it?______________ When did it start?__________	What relieves it?__________ What makes it worse?________	Is it? (Circle All that Apply) Sharp Dull Burning Throbbing Aching Constant	Circle All that Apply: Pain Numbness Weakness Stiffness Other:______________

Was this the result of an injury? (Yes / No)	Did the injury occur at work? (Yes / No)
Is the problem work related? (Yes / No)	Have you had this problem before? (Yes / No)

Allergies: (Circle All That Apply)

(No Known Drug Allergies)

Allergy/Unusual Reaction to:
(Penicillin) (Sulfa Drugs) (Any Antibiotic) (Codeine) (Aspirin) (Novocaine) (Epinephrine) (Cortisone) (Tape) (Latex) (Iodine) (IVP Dye)

Allergy to Medications:	1.__________	2.__________	3.__________

Medications:

Medication	Dosage	Medication	Dosage
1.__________		6.__________	
2.__________		7.__________	
3.__________		8.__________	
4.__________		9.__________	
5.__________		10.__________	

What type of surgery have you had in the past?

Complications with any surgeries?

Dr. Glen Beede Dr. Gary Driver Dr. Gregory Jaryga

Patient Name:____________________

Vitals: Height: __________FT_________Inches Weight:____________LBS
Tobacco Use: (Never) (Former Smoker / Year Quit_________) (Current Smoker____#Pack/Day____#Years)
Alcohol Use: (Never) (Socially) (Weekly) (Daily) (Excessive) (History Alcoholism) Substance Abuse: (Yes / No)

Social History:

Female Reproductive:

Are you or could you be pregnant? (Yes / No)
Birth Control Pills (Yes / No)

Review of Systems: Have you RECENTLY experienced any of the following?
(Circle Positive Symptoms)

Constitutional: Fever, Chills, Weight Gain/Loss, Night Sweats, Weakness, Fatigue
Eyes: Double Vision, Blurring, Difficulty Seeing
ENT: Deafness, Sinusitis, Hoarseness, Vertigo, Ringing of the Ears, Hearing Loss, Sore Throat, Problems Swallowing
Respiratory: Shortness of Breath, Wheezing, Spitting Blood, Cough
Digestive: Abdominal Pain, Constipation, Diarrhea, Bleeding, Loss of Appetite, Nausea, Vomiting, Jaundice, Black Stool
Urologic: Pain when Urinating, Increased Frequency or Urgency of Urination, Hesitancy, Loss of Bladder Control, Bleeding, Incontinence, Urethral Discharge
Skin: Rashes, Lesions that do not heal, Itching, Redness
Blood & Lymph: Anemia, Bleeding Tendencies, Swollen Nodes
Neurologic: Seizures, Loss of Balance, Loss of Coordination, Paralysis, Weakness, Loss of Memory, Headache, Fainting, Tremors, Numbness
Musculoskeletal: Stiffness, Joint Swelling, Joint Pain, Deformity, Muscle Wasting, Spine Pain Radiating to Arm/Leg
Psychiatric: Depression, Anxiety, Hallucinations, Sleep Disturbances
Endocrine: Excessive Thirst, Excessive Urination, Heat/Cold Intolerance, Increased Appetite
Cardiovascular: Chest Pain, Palpitations, Irregular/Rapid Heartbeat, Murmur, Leg Swelling, Shortness of Breath with Exertion/When Lying Down, Pain in Legs with Walking
Allergic & Immunologic: Hives, Eczema, Itching
Gynecologic: Breast Masses, Pain, Discharge

TRINITY FOOT & ANKLE SPECIALISTS PLLC

Patient Name:____________________

Past Medical History / Family History: *Check any medical problems that you have had. Indicate if the problem is current or resolved. Additionally check if there is a family history of any/all medical problems.*

	Your History	Family History		Your History	Family History
General			**GI**		
Stroke			Esophageal Reflux		
Cancer,Type______________			Diarrhea		
Chemotherapy			Constipation		
Radiation			Liver Disease		
Rheumatic Fever			Hepatitis		
Allergy			Irritable Bowel Syndrome		
Environmental Allergies			**Bladder/Kidney**		
Immune Compromise			Frequent Urination		
Neurology			Burning on Urination		
Change of Memory			Prostate Problems		
Change of Balance			Kidney Failure		
Change of Sensation			**Musculoskeletal**		
Erectile Dysfunction			Leg pain at night		
Psychological			Painful Joints/Arthritis		
Depression			Painful Muscles		
Anxiety/Panic Attacks			Calf pain when walking		
HEENT			Swelling Ankles/Legs		
Change of Headaches			Degenerative Arthritis		
Change of Dizziness			Rheumatoid Arthritis		
Change of Vision			Healing/Keloid problems		
Ringing Ears			Restless Leg Syndrome		
Sinus Congestion			Fibromyalgia		
Trouble Swallowing			CRPS		
Respiratory			**Lymph/Hematology**		
Asthma			Bleeding Problems		
Short of Breath			Pain/Swollen Glands		
COPD			Anemia		
Emphysema			**Endocrinology**		
Sleep Apnea/CPAP			Thyroid Disease		
Pulmonary Embolism			Hormone Replacement		
Cardiac			Diabetes		
Chest pain/Angina			Gout		
High Blood Pressure			Osteoporosis		
Heart Disease			**Skin**		
High Cholesterol			Rashes		
Heart Attack			New Growth/Lumps		
Pacemaker/Defibrillator			Color change in mole		
O2 at home			Eczema/Dry Sking		
Arrhythmia/Irregular heart beat			Psoriasis		
Atrial Fibrillation			**Other**		
CHF			HIV		
Artificial Heart Valve			Sexually Transmitted Disease (STD)		
History of Blood Clots			Hepatitis A/B/C		
Peripheral Arterial Disease			Other:______________________________		