(972) 274-5708
FAX: (972) 274-1471
WWW.INFINITYFOOTANDANKLE.COM

Infinity
FOOT & ANKLE
PARUL K PATEL, DPM

2611 Bolton Boone Dr
Desoto, Tx 75115

341 Wheatfield Dr. #100
Sunnyvale, TX 75182

2501 Oaklawn Ave #201
Dallas, TX 75219

PATIENT INFORMATION: (Please use full legal name, no nicknames) **TODAY'S DATE**:_____

Last Name: _____First Name: _____Middle Initial:_____

Address:_____

City:_____ State:_____ Zip code:_____

Date of Birth: _____ Age: _____ Sex:_____ Marital Status:_____ Driver's Lic #:_____

Social Security Number: _____ Email: _____

Phone: (_____) _____-_____Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Employer Name: _____

Employer Address: _____

Emergency Contact Name: _____ Phone #: (_____) _____-_____

Primary Care Physician: _____ Phone #: (_____) _____-_____

Local Pharmacy Used: _____ Address or Phone: _____

GUARANTOR INFORMATION: (Please use full legal name, no nicknames)

Relationship of Guarantor to Patient: _____Self _____Spouse _____Parent _____Other (Specify):_____

Last Name: _____First Name: _____Middle Initial:_____

Address:_____

City:_____ State:_____ Zip code:_____

Date of Birth: _____ Age: _____ Sex:_____ Marital Status:_____ Driver's Lic #:_____

Social Security Number: _____ Email: _____

Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Employer Name: _____

Employer Address: _____

How Did You Hear About Us? (Please Fill Out) _____

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DISCLOSURES AND CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Infinity Foot and Ankle, PA or Parul K. Patel, DPM, the physician individually, for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Infinity Foot and Ankle, PA or Parul K. Patel, DPM, on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Infinity Foot and Ankle, PA Patient Information Privacy Policy. I hereby authorize Infinity Foot and Ankle, PA or Parul K. Patel, DPM, the physician individually, to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize an Infinity Foot and Ankle, PA representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including, but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Infinity Foot and Ankle, PA to that effect in writing.

LAB/XRAY/DIAGNOSTIC SERVICES/DURABLE MEDICAL EQUIPMENT:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, DME, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance company for any reason.

CONSENT TO TREATMENT

I hereby consent to evaluation, testing and treatment as directed by Parul K. Patel, DPM or his/her designee.

PATIENT SIGNATURE_____**DATE:**_____

GUARANTOR SIGNATURE:_____

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HIPAA CONSENT

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workerS.

PLEASE CIRCLE YOUR RESPONSE

1. May we leave messages concerning your APPOINTMENTS with co-worker, receptionist or secretary that might regularly answer your calls?	YES	NO	N/A
2. May we leave MESSAGES on a voice mail at work?	YES	NO	N/A
3. May we discuss your appointments/treatments with your spouse?	YES	NO	N/A
4. If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parent(s)/guardian?	YES	NO	N/A
5. If you are over the age 18, may we discuss your appointments/ treamtents with your children?	YES	NO	N/A

THIS AUTHORIZATION APPLIES TO VERBAL EXCHANGES/MESSAGES ONLY WITH AUTHORIZED FRIENDS/FAMILY/AGENTS. Other requests (documents, prescriptions, samples, etc.) must be accompanied by a signed authorization from you (the patient) with the actual date of service.

You must inform us in writing of any changes in your directives. This record takes effect January 1, 2009 and will be kept in your file. By signing below you acknowledge the above and acknowledge receipt of the Notice of Privacy Practices.

SIGNATURE:_____DATE:_____

PRINTED NAME:_____ DATE OF BIRTH:_____

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PATIENT NAME: _____**DATE OF BIRTH**:_____

CURRENT PROBLEM:

_____

_____

_____

CURRENT MEDICATION LIST: (Include dosage, over the counter, and vitamins/supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES (Check all that apply):

_____ Penicillin _____Sulfa _____Codeine _____Iodine/Shellfish _____ Tape

_____Latex _____Local Anesthetic _____General Anesthetics _____Other Food or Drug:_____

PREVIOUS INJURIES: **PREVIOUS SURGERIES:** **PREVIOUS OPERATIONS:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

PREVIOUS FOOT CONDITIONS:

_____

_____

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SOCIAL HISTORY

Occupation: _____ _____Single _____Married _____Widowed

Athletic Activities: _____ Current Height: _____ Current Weight: _____

Alcohol: _____ oz/day/week Tobacco:_____pack(s)/day for _____years Current shoe size:_____

FAMILY HISTORY

Diabetes:_____ Cancer (type):_____ Heart Disease:_____ Hypertension:_____

Sickle Cell Anemia: _____ Other:_____

ILLNESSES (Please circle all that apply)

SYSTEMIC DISEASE:

Diabetes
Hypertension
Heart Disease
Heart Attack
Murmur
Mitral Valve Prolapse
Stroke

HEENT:

Headaches
Eye Problems
Hearing Problems

PSYCHOLOGICAL:

Anxiety
Depression

ARTHRITIS:

Osteoarthritis
Rheumatoid
Gout

RESPIRATORY:

Asthma
Bronchitis
COPD
Tuberculosis
Emphysema Other
Lung Disease

Alcohol Dependence
Drug Dependence

VASCULAR:

Anemia
Sickle Cell
Bleeding Disorders
Poor Circulation
Night Leg Cramps
Leg Pain with walking
Vein Problems/Varicose
Swelling/Phlebitis
Leg Ulcerations
Blood Clots

MISCELLANEOUS:

Epilepsy
Thyroid Disease
Muscle Disease
Kidney/Dialysis
Cancer (type):_____
Liver/Hepatitis

GASTROINTESTINAL:

Ulcers
Hiatal Hernia
Bowel Disorders
Acid Reflux/GERD

OTHER ILLNESSES:_____

_____