411 Lantern Bend, Suite 240
Houston, Texas 77090
Tel (281) 444-6300 Fax (832)375-1247
Email: info@MFASclinic.com

NEW PATIENT INFORMATION FORM

Patient's Name **as it appears on Insurance Card** | Date of Birth | Sex ❑MALE ❑FEMALE

Address | Home # ( ) | Cell # ( )

City State Zip

SSN

☐ **pt refused to give SSN**

Driver's License # ______________________

Expiration Date: ______________________

Marital Status

☐ Single ☐ Married ☐ Divorced

☐ Separated ☐ Widow ☐ Student

Email Address

Primary Care Physician: First Name:_________________ Last Name: ________________ Phone #: ( )

Who referred you to our office?

☐ Friend, Family Member, Employee ___________________________

☐ Website _________________________________

☐ Emergency Room _____________________________________

☐ Internet Search (Google, Yahoo, etc.)____

☐ Reception Area Display

☐ Other ____

☐ **CASH Patient**

☐ **Workers' Compensation (Ask our staff for a WC info. form)**

INSURANCE INFORMATION

☐ **PRIMARY** INSURANCE Company Name

____

Policyholder or Person Responsible for the bill:

☐ Same as above.

Name, If different than patient: ___________________________

Policy Holder's Date of Birth _______________________________

Policy Holder's SSN _______________________________

Relationship of policy holder to patient

☐ Self ☐ Child ☐ Spouse ☐ Other ________________

☐ **SECONDARY** INSURANCE Company Name

____

Policyholder or Person Responsible for the bill:

☐ Same as above.

Name, If different than patient: ___________________________

Policy Holder's Date of Birth _______________________________

Policy Holder's SSN _______________________________

Relationship of policy holder to patient

☐ Self ☐ Child ☐ Spouse ☐ Other ________________

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME _______________________________

Relationship to patient:

☐ Spouse ☐ Parent ☐ Friend ☐ Other __________

Home Phone ( )

Cell Phone ( )

Email ____

TREATMENT AUTHORIZATION: I hereby authorize Dr. Moore or his associate to treatment my ankle and/or foot.

Patient / Guardian Signature_______________________________________ Date: ____________________________

PAYMENT AUTHORIZATION: The above information is true, to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Moore Foot and Ankle Specialists, PA or insurance company to release any information to process my claims.

Patient/Guarantor Signature _______________________________________ Date ____________________________

PATIENT MEDICAL HISTORY Date: _______________

LAST NAME ____________________________________, **FIRST NAME** _________________________ SEX: M / F

AGE____________ SHOE SIZE______________ HEIGHT_____________ WEIGHT_______________

☐ **WERE YOU INJURED WHILE WORKING?** ____________ **DID YOU NOTIFY YOUR EMPLOYER?** ___________

OCCUPATION_____________________________ DUTIES____

DESCRIPTION OF PROBLEM(S)

TYPE OF PAIN: SHARP SHOOTING DULL BURNING THROBBING ACHING TINGLING OTHER ________

DURATION / FREQUENCY OF PROBLEM(S) / PAIN

Have you had this problem before? _______ If yes, when? _____________________________

Have you sought professional treatment for this before? _________ If yes, when ____________

What helps to relieve the problem(s)? ____

What causes the problem(s) to worsen? ____

MEDICAL HISTORY

☐ Unremarkable medical history
☐ Diabetes Type _____, controlled/uncontrolled, diagnosis date: ____
☐ Other ____

ALLERGIES

☐ **No Allergies of any kind** ☐ Seasonal Allergies ☐ Adhesive on bandages ☐ Latex Gloves

☐ Other ____

☐ **No Known Drug Allergies – NKDA**

☐ **MEDICATION ALLERGIES:** ____

MEDICATIONS (*Including Aspirin products, Allergy, Cold, Diet medications, Supplements, and Vitamins):

☐ **SEE ATTACHED LIST**
☐ **I am not taking any medication at this time**; No known medications - NKM

Medication_________________________ Dosage _________ ____ x day or ____ x week Prescribing Doctor: __________________	Medication_________________________ Dosage _________ ____ x day or ____ x week Prescribing Doctor: __________________
Medication_________________________ Dosage _________ ____ x day or ____ x week Prescribing Doctor: __________________	Medication_________________________ Dosage _________ ____ x day or ____ x week Prescribing Doctor: __________________
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HOSPITALIZATIONS / SURGERIES (*This includes all Hospital/Surgery including foot/ankle):

☐ **I have not been hospitalized for anything.** ☐ **I have not had any type of surgery elective or non-elective**

Date of Surgery Month, Year	Procedure/Surgery Description List any complications, if applicable	Left – Right – Both

FAMILY MEDICAL HISTORY:

Relative	Still Living; Age	Medical Condition(s) or **write "Unknown"**	Deceased; Date or Year	Cause of Death
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Other family conditions				

SOCIAL HISTORY:

Do you exercise? _______ How often do you exercise? _______ x per week Type of exercise: ______________________________

TOBACCO/ALCOHOL/SUPPLEMENTS:

☐ NON-DRINKER or Type of Alcohol_________________, ______ x day x _____ per week or Quit Drinking ___________ date

☐ NON-SMOKER or Type of Tobacco_________________, ______ x day x _____ per week or Quit Smoking ___________ date

☐ I DO NOT DRINK CAFFEINE or Type of Caffeine _______________, ______ x day x _____ per week

WEIGHT MANAGEMENT & HEALTHY LIVING TIPS:

☐ I am interested in receiving information on a complete weight management system.

☐ I would like to be added to your new email list for weekly healthy living tips.

LEG VEINS:

☐ I would like information regarding treatment for painful or unsightly leg veins, e.g. spider/varicose veins.

I BELIEVE THE INFORMATION I HAVE PROVIDED REGARDING MY MEDICAL HISTORY TO BE TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE.

Print Patient Name/ Guardian: ___________________________

Signature of patient/guardian: ____________________________ Date: ________________

X-RAY CONSENT…….EVERYONE, Females must also complete the next section of the X-Ray Consent.

I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed x-rays.

Print Patient Name/ Guardian: ___________________________

Signature of patient/guardian: ____________________________ Date: ________________

X-RAY CONSENT…….FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

☐**To my knowledge I am not pregnant**

☐**I am pregnant**

☐**I'm not sure if I'm pregnant**

☐**My menstrual period is late**

☐**I have an IUD**

☐**I have had a tubal ligation**

☐**I have had a hysterectomy**

☐**I have begun menopause**

With full understanding of the above, and believing that I am not currently at risk, I will allow for x-rays to be taken if required to diagnose my condition.

Print Patient Name/ Guardian: ___________________________

Signature of patient/guardian: ____________________________ Date: ________________

MOORE
FOOT and ANKLE Specialists

Patient Initials ___________

Yes	No	Release of Information
		I authorize Dr. Robert Moore's office to **release medical records** to other requesting physicians (including AIDS/HIV records).
		I authorize Dr. Robert Moore's office to **discuss medical issues/records, lab results & diagnostic test results with pertinent personnel.**
		I authorize Dr. Robert Moore's office to **send correspondence to my home address, other than financial statements.**
Yes	**No**	**Email Permissions**
		I authorize Dr. Robert Moore's office to **transmit information** to the following email address: ____ ☐ Appointment Reminders ☐ Surgery Scheduling Information ☐ Foot Care Tips ☐ Lab Results ☐ Invoices ☐ Weight Management ☐ Medical Records ☐ Healthy Living Tips

DURABLE MEDICAL EQUIPMENT **Patient Initials ___**

In the event that Moore Foot & Ankle Specialists, PA orders crutches, walker, cane, wheel chair, bedside commode or a shower chair the patient will need to sign a payment authorization that assigns benefits to said practice so that they are reimbursed and/or the DME supplier, however, the patient is ultimately responsible for the balance. The authorization will also include a release of information clause.

ORTHOTICS AGREEMENT **Patient Initials ___**

Although we routinely check orthotics coverage with insurance companies, eligibility verification is not a guarantee of payment. Orthotics payment is based on the terms of enrollee's Participation Agreement and the terms of the enrollee's benefit plan. Should insurance reimbursement for your orthotics be denied, we will appeal the claim once as a courtesy. Remaining balance will be the patient's responsibility.

NOTICE OF PRIVACY PRACTICES – NPP **Patient Initials ___**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected healthcare information about your for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.

FINANCIAL POLICIES AGREEMENT & ASSIGNMENT OF BENEFITS **Patient Initials ___**

1. All co-pays, deductibles, and co-insurances are due at the time of services.
2. Insurance benefits will be assigned to the physician. All insurances will be filed for the patient provided that we are able to identify eligibility.
3. It is your responsibility to know your insurance plan requirements and provide a referral from your primary care physician when required.
4. Financial arrangements will be considered on an individual basis.
5. Balances will be turned over to our collection agency if not paid in a reasonable amount of time.
6. Statements will be mailed the first week of each month and a payment is expected 14 days from receipt of invoice.
7. We accept Cash, Visa, and MasterCard. Checks for mailed payments only. Payments can be made by mail or by phone.
8. There will be a 25.00 fee for all returned checks.

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Moore Foot and Ankle Specialists, PA or insurance company to release any information to process my claims.

Print Patient Name/ Guardian: ____________________________

Signature of patient/guardian: _____________________________ Date: _________________