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Phone (901) 207-5176 Fax (901) 201-5125

PATIENT INFORMATION FORM

DATE: ___/___/_____

PATIENT NAME: _____ ___ **DATE OF BIRTH:** ___/___/___ **SEX:** M F
LAST FIRST MI

HOME ADDRESS: _____ **CITY/STATE:** _____ **ZIP:** _____

SS#: _____ **HOME#:**(___) _____-_____ **CELL#:**(___) _____-_____

EMPLOYER: _____ **WORK#:**(___) _____-_____

MAY WE LEAVE A MESSAGE AT THE NUMBERS PROVIDED? YES _____ NO _____

E-MAIL: _____ **PRIMARY LANGUAGE:** _____

RACE: _____ **ETHNICITY:** _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** (___) ___-_____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE #:** (___) ___-_____

PRIMARY CARE DOCTOR: _____ **PHONE:** _____
DATE LAST SEEN: _____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
NAME(S) _____ **PHONE#** _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ **RELATIONSHIP TO PATIENT?** _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME _____ DATE OF BIRTH _____ EMPLOYER _____

POLICY # _____ **GROUP #** _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS _____ CITY/STATE _____ ZIP _____ PHONE # (___) _____-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

POLICY # _____ **GROUP #** _____

NAME:_____ DOB:_____

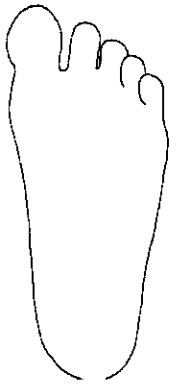
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

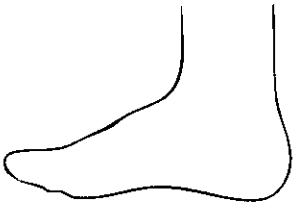
LEFT FOOT

TOP OF FOOT



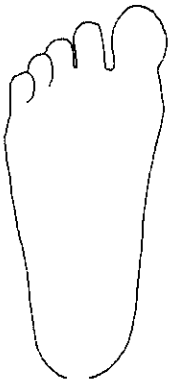
BOTTOM OF FOOT

INSIDE OF FOOT



OUTSIDE OF FOOT

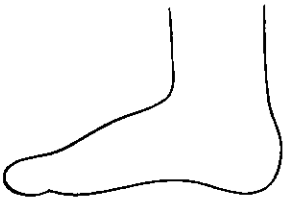
RIGHT FOOT



BOTTOM OF FOOT

TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

NAME:_____ DOB:_____

YOUR MEDICAL HISTORY

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME / DOSE:	NAME / DOSE:

PHARMACY: _____ **ADDRESS:** _____

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NO KNOWN ALLERGIES

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

VITAL SIGNS (FOR OFFICE USE ONLY)
BLOOD PRESSURE:_____/_____ PULSE:_____ PULSE OX:_____
HEIGHT:_____ WEIGHT:_____ A1C:_____ SHOE SIZE:_____

NAME:_____ DOB:_____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ OTHER _____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN–AGE(S) _____ ☐ PET(S)–WHAT KIND? _____
☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY
TYPES OF EXERCISE: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? ☐ PHYSICIAN ☐ INTERNET ☐ INSURANCE ☐ FRIEND OR FAMILY

IF FRIEND OR FAMILY, WHO REFERRED YOU?_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN IF NOT THE PATIENT, RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE DATE

Christopher L. Hendrix, DPM, PC
Authorization from Patient or Legal Representative

Consent to Treat: The undersigned consents to any initial or follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient. The undersigned agrees that it is their responsibility to contact and/or schedule with our office any follow up visits, other services, prescriptions and items ordered for the patient.

Assignment of Benefits: I hereby irrevocably assign, transfer and convey to Christopher L. Hendrix, DPM, PC, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I'm entitled under an employee benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I received from Christopher L. Hendrix, DPM, PC.

Medicare Assignment: I certify that the information given by me in applying for payment under XVIII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries as well as any information needed for filing a Medicare claim; I request that payment and authorized benefits be made on my behalf. I assign benefits payable for services to Christopher L. Hendrix, DPM, PC

Authorization to Release Information: I consent and authorize Christopher L. Hendrix, DPM, PC and its agents to release my health information for the purpose of payment, treatment, and healthcare operations to any of the following: insurance company and its affiliates, any practitioner, support staff or facility involved in my plan of care or transfer of care. In addition I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy notice. The HIPAA Notice of Privacy Practices is available in the office. I have read/had the opportunity to read my HIPAA rights.

Designation of Authorized Representative: I designate and appoint Christopher L. Hendrix, DPM, PC (and its agents) as my authorized representative and authorize it to act on my behalf to 1) request and receive a copy of the summary plan description, 2) pursue a benefit claim, 3) appeal an adverse benefit determination, and/or 4) file a legal/equitable action to recover benefits from my employee benefit plan, insurance policy, and any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child, any requests for documents relating to this claim and appeal of an adverse determination of the claim.

Financial Agreement: I hereby promise to pay for all products received or services rendered to me/my child to the extent I am legally responsible for such payment. According to the language of the physician's insurance contract, I understand that I am responsible for all health insurance copayments, deductibles, coinsurances, OTC- over the counter convenience items and NCS- non-covered services and any other amounts that apply at the time of service or at the preoperative appointment. Regardless of the assignment of benefits, should the insurance misrepresent their coverage or delay payment of a claim greater than 60 days, as the designated responsible party, I am responsible for all the monies owed to Christopher L. Hendrix, DPM, PC. I also understand that the insurance policy is a contract between me and the insurance company; therefore the policy holder should contact the insurance carrier first when there are questions regarding explanation of benefits.

The undersigned certifies that he/she has read and understands the foregoing statements, and is either the patient, or is duly authorized by the patient as the patient's general agent or the guarantor of the patient to execute the above and accepts its terms. This document shall remain in force until a written revocation by me is delivered to Christopher L. Hendrix, DPM, PC.

Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date

Christopher L. Hendrix, DPM, PC- Notification of Office Policies and Procedures

Emergency/After Hours: During a medical emergency, patients should call 911 or proceed to the nearest emergency room. The facility will contact our physician for post-operative complications and other urgent situations.

Refills and Medication: Refills and Medication will be completed on the same day **if** received/requested Monday through Thursday before 3:00 p.m. and all others will be handled the next business day except on Fridays.

Payment: Our office accepts Visa, MasterCard, Discover, Cash or Checks.

Returned Checks: A **$35** fee will be charged to the patient on all returned checks. Any NSF or Closed Account will result in future services on a pre-pay cash or credit basis.

Delinquent Accounts: In the event that your account is placed with a Collection Agency, a collection-fee in the amount of **33 1/3%** of the then outstanding balance may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all cost of collection including attorney fees and court cost. You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

"No Show" Appointments: A **$25** fee will be charged to the patient for any "No Show" appointments.

Appointment Hold: Repetitive broken appointments, non-compliance, hostile behavior, and/or financially deficient accounts will result in appointment hold and/or the termination of the Doctor/patient relationship. A 30 day notice will be given should the situation result in a transfer of the patient's care.

Over the Counter Convenience Items (OTC): Our office will not submit claims for OTC items (eg. Shoe inserts, Surgical shoe(s), Toe pads/Correctors/Caps, etc…)

Returns: Only unworn and non-custom items are returnable within 14 days of receipt, if no visible signs of wear, tear or odor. Custom items are tailored to meet individual needs; custom items are non-returnable, non-refundable.

Medical Records/FMLA or Short Term Disability Forms: Copies of the patient's medical records will be given to the patient at no charge. A **$5** fee will be charged to the patient if the patient requests copies of their x-rays on a disk. A **$20** fee will be charged to the patient for completing FMLA or Short Term Disability Forms.

Non-Covered Services: I have been informed that the services listed may be denied by any insurance as services not covered by my plan. I agree to be fully responsible for payment of any services provided that are non-covered or excluded from my insurance policy. Examples- Debridement or cutting of nails (routine care), Paring or a lesion (Corns & calluses), Custom orthotics, etc.

Referral: If my insurance plan requires a referral in order to be treated, it is my responsibility to obtain the referral prior to being treated. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

The undersigned certifies that he/she has read and understands the foregoing statements, and is either the patient, or is duly authorized by the patient as the patient's general agent or the guarantor of the patient to execute the above and accepts its terms.

Print Name of Patient or Legal Representative	Signature	Relationship to Patient	Date