Advantage
FOOT CARE OF HOUSTON

(832) 835-1442
doctor.mantha@gmail.com
www.footcareofhouston.com

NEW PATIENT INFORMATION

NAME: _____ DOB: _____ AGE: _____
PATIENT EMAIL: _____ APPT DATE: _____
PHARMACY ADDRESS: _____
PHARMACY PHONE: _____
HOW DID YOU FIND US? ☐ SELF REFERRAL ☐ ZOCDOC.COM
☐ DOCTOR/THERAPIST THAT REFERRED YOU TO US: _____
GENDER: ☐ MALE ☐ FEMALE
RACE/ETHNICITY:

CHIEF COMPLAINT

Reason for visit: _____
_____
Location of your pain: ☐ Ankle/Foot ☐ RT ☐ LT ☐ Both

HISTORY OF PRESENT ILLNESS

Date of injury or symptom onset: _____
Type of injury: ☐ Sports Injury ☐ Job Accident
☐ Car Accident (Were you the Driver ☐ Passenger ☐ Seatbelted ☐)
☐ Other Injury (explain): _____
Please describe how you injured yourself: _____
_____
Please describe your current symptoms: _____
_____

Circle the number that corresponds to the severity of your pain on a scale of 0 - 10.
"0" means no pain and "10" is the worst pain you can imagine.

At its worst: ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

At its best: ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Which of the following best describes the *character* of your pain:

Timing: ☐ Continuous, steady, constant ☐ Rhythmic, periodic, intermittent
☐ Brief, momentary, transient (Frequency: _____ Duration: _____)

Quality: ☐ Throbbing ☐ Burning ☐ Superficial ☐ Sharp
☐ Aching ☐ Tingling/numbness ☐ Deep ☐ Dull

What makes your pain worse? _____
What makes your pain better? _____
How long/far can you: Stand _____ Walk _____
Since your injury/ problem is your pain: ☐ Better ☐ Same ☐ Worse
Shoe size? _____ What is your occupation? _____
Shoe Type (describe): Work Gym Home

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PREVIOUS TREATMENT

Have you had treatment any previous treatment? ☐ No ☐ Yes

Have you been to the ER for this? ☐ No ☐ Yes

Have you had any of the following tests or procedures performed:

X-Rays? ☐ No ☐ Yes MRI? ☐ No ☐ Yes

CT Scan? ☐ No ☐ Yes EMG? ☐ No ☐ Yes

Other (please explain): _____

Medical and physical therapy? ☐ No ☐ Yes

Doctor or provider: _____

Date of 1st visit: _____ Date of last visit: _____

Diagnosis given: _____

Medications given: _____

Treatment provided:

CURRENT MEDICATIONS

CURRENT MEDICATIONS

Name	Dosage	Dosage per day?

MEDICATION ALLERGIES

MEDICATION ALLERGIES

Name	Reaction

Allergies/reactions to iodine, shellfish, IVP dye, or contrast media? ☐ No ☐ Yes

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PAST MEDICAL HISTORY

☐ Anxiety	☐ Heart Attack	☐ Polio	☐ Thyroid trouble	☐ Depression	☐ Hypertension
☐ Asthma	☐ Heart Murmur	☐ Stroke	☐ High Cholesterol	☐ Alcoholism	☐ Liver disease
☐ Cancer	☐ Lung Disease	☐ Parkinson's	☐ Rheumatic Fever	☐ Hepatitis	☐ Chronic pain
☐ Diabetes	☐ Ulcers/PUD	☐ Arthritis	☐ Claustrophobia	☐ Psychiatric illness	

☐ Other: _____

Have you ever had similar symptoms/injury before? ☐ No ☐ Yes

If yes, when: _____

Please describe briefly: _____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐ No ☐ Yes

If yes, please list type of surgery and approximate date:

Date	Surgery Type

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

☐ Anxiety	☐ Heart Attack	☐ Polio	☐ Thyroid trouble	☐ Depression	☐ Hypertension
☐ Asthma	☐ Heart Murmur	☐ Stroke	☐ High Cholesterol	☐ Alcoholism	☐ Liver disease
☐ Cancer	☐ Lung Disease	☐ Parkinson's	☐ Rheumatic Fever	☐ Hepatitis	☐ Chronic pain
☐ Diabetes	☐ Ulcers/PUD	☐ Arthritis	☐ Claustrophobia	☐ Psychiatric illness	

☐ Other: _____

SOCIAL HISTORY

Marital Status: (Check one or more)

☐ Single	☐ Divorced	☐ Living together	Number of children: _____
☐ Married	☐ Widowed	☐ Separated	Ages: _____

Do you smoke?	☐ No	☐ Yes	How often? _____
Previous Smoker?	☐ No	☐ Yes	Date stopped? _____
Do you drink alcohol?	☐ No	☐ Yes	Drinks/wk? _____
Do you use recreational drugs?	☐ No	☐ Yes	How often? _____
Are you currently employed?	☐ No	☐ Yes	Occupation?

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REVIEW OF SYSTEMS

Please mark those items which you currently experience:

GENERAL

- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss
- ☐ Weakness
- ☐ Fatigue
- ☐ Chills
- ☐ Night sweats

DERMATOLOGIC

- ☐ Jaundice
- ☐ Itching/rash
- ☐ Lesions
- ☐ Easy bruising

HEAD/HEARING& VISION

- ☐ Trauma
- ☐ Headaches
- ☐ Blindness
- ☐ Tenderness
- ☐ Rings around lights
- ☐ Ringing in ears
- ☐ Changes/loss
- ☐ Discharge
- ☐ Blurred vision
- ☐ Dizziness

PULMONARY

- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Coughing up blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Leg swelling
- ☐ Shortness of breath with exertion
- ☐ Racing heart

GASTROINTESTINAL

- ☐ Nausea
- ☐ Bloody stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Vomitting
- ☐ Stool color changes
- ☐ Heartburn
- ☐ Incontinence of bowels

GENITOURINARY

- ☐ Blood in urine
- ☐ Pregnancy
- ☐ Pain/burning on urination
- ☐ Painful menstruation
- ☐ Venereal disease
- ☐ Sexual problems
- ☐ Urgency/frequency w/urination
- ☐ Irregular menstruation
- ☐ Vaginal discharge
- ☐ Incontinence
- ☐ Menopause

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Joint swelling
- ☐ Trauma

NEUROLOGICAL

- ☐ Loss of Sensation
- ☐ Seizures
- ☐ Numbness and Tingling

PSYCHOLOGICAL

- ☐ Sadness
- ☐ Anxiety
- ☐ Depression

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OFFICE AND FINANCIAL POLICIES

Welcome to Advantage Foot Care of Houston.
Please take the time to review our Office and Financial Policies

Patient Name _____ **DOB** _____

PAYMENT POLICY

Payment is expected at the time of service. Your copay, coinsurance, and/or deductible is due at time of visit. For your convenience, we accept checks, Visa, or MasterCard as a form of payment. Please note that if you are sent for any testing the facility which you receive your services have their own separate billing and collections practices and you must contact them regarding any balances.

INSURANCE POLICY

We must copy your insurance card and valid state DL or ID for services to be rendered. We will bill your insurance company. For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility. Please inform our staff immediately of any insurance changes.

NON-COVERED SERVICE POLICY

Understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services.

LATE ARRIVALS

For our physician to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 20 minutes late, our office will reschedule your appointment to a new date and time.Tardiness affects your patient care as well as those patients that have a scheduled time after you.

We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause the provider to run late. Please be patient in these circumstances.

MEDICAL RECORDS

Should you request a copy of your medical records, please allow our office 7-10 business days for completion.

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FORMS POLICY

Should you request our office to complete forms on your behalf for disability, work status (besides workers comp), FMLA, etc., there will be a charge of $35.00 per form. Please allow 7 business days for any forms to be completed. For any medical records requested by the patient for any reason and given to the patient there will be a $25.00 charge. Please allow 5 business days for records to be prepared and ready for pick up. Payment is due at the time the request for medical records is turned in or when the request for any forms to be completed.

PRESCRIPTIONS

Appointments are required for medication refills. Please contact our office a minimum of 10 days prior to your scheduled refill date. Phone call refills are not allowed.

RETURNED CHECKS

Our office charges a $30.00 fee for all account closed, stop payment or nonsufficient funds returned checks.

REFERRALS & AUTHORIZATIONS

If a referral is required by your insurance carrier please make sure that you get one from your primary care. If no referral exists on file or your referral has not been received, your appointment will need to be rescheduled until we have received referral or authorization. Our office will obtain authorization for any procedure, test, or surgeries prior to scheduling your appointment. Please be aware authorizations and referrals are not a guarantee of payment.

WORKMAN'S COMPENSATION

Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: Adjustors Name, claim status, (litigation, supportive care, claim closed, new injury), DOI, carrier, claim number and claims address. Please have this information available prior to your appointment time.

THIRD PARTY BILLING

Our office does not accept medical liens or motor vehicle accident cases. If you are involved in any motor vehicle accidents you must provide us with the responsible party claim number, adjuster name and carrier name to verify if the policy PIP has been exhausted or does not exist.

Patient/Guardian Signature **Date**

Printed Name

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ASSIGNMENT OF BENEFITS

Patient Name _____ **DOB** _____

ACCT NUMBER _____

ASSIGNMENT OF BENEFITS

I, or authorized representative/legal guardian acting on behalf of the patient herby authorize payment of insurance benefits under the terms of my policy directly to Advantage Foot Care of Houston for services rendered. I am financially responsible and will pay for charges not covered by my insurance companies. _____ (initials)

FINANCIAL AGREEMENT AND STATEMENT OF RESPONSIBILITY

For and in consideration of services rendered or to be rendered the facility, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non- covered charges. I understand payment in full is due at the time services are rendered or payment arrangements are to be made before my appointment. I understand the amount quoted by Advanced Foot Care of Houston as being my responsibility is an estimate only and any patient balance remaining after my insurance has processed my claim will be billed to me and due within 30 days. I understand that it is my responsibility to inform the office with a minimum of a 24-hour advance notification if I am unable to make my appointment. _____ (initials)

CONSENT TO MEDICAL TREATMENT BY PHYSICIAN

I, or authorized representative /legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures, in office surgical procedures and such medical treatment as the physician consider to be necessary in her judgement. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatment or examination at the facility. _____(initials)

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ACKNOWLEDGMENT OF REVIEW OF PRIVACY PRACTICES

I, the undersigned, have reviewed the Privacy Practices, which explains how my medical information will be used and disclosed. I understand that the facility may use several resources to communicate PHI with me using these methods. I understand that I am entitled to receive a copy of the Privacy Practices. _____ (initials)

RELEASE OF PATIENT HEALTHCARE INFORMATION

I hereby authorize the facility and any medical subcontracted providers, to release or obtain patient healthcare information, including but not limited to reports, prior films/images, test results, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personal of another health care entity for the purpose of providing current continuum of care including to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to , my insurance carrier, Medicare, Medicaid, and any other payor or agency . _____(initials)

PHYSICIAN OWNERSHIP DISCLOSURE

This is to inform you that your physician may or may not have an investment interest in the facility you are referred to. This information is being provided to you to help you make an informed decision about your healthcare. Should you be referred to a facility at any time and you prefer to use a different provider, you will be advised of alternative. You should not be treated differently by your physician, physician's staff or the facility if you choose to choose a different facility. _____(initials)

DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS

I gave permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decision to the family members and others listed below:

NAME	RELATIONSHIP
NAME	RELATIONSHIP

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PHOTOGRAPHY CONSENT

I consent for medical photographs to be taken. I understand that the photographs may be used in my medical record for documentation, for educational purposes, or for other reasons. My consent for photographs for office reference, educational purposes, or the internet is voluntary, and my refusal to consent to photographs will not affect my medical care.

Please initial those uses to which you agree:

_____ **Medical file- Photographs will be used as part of the medical documentation**

_____ **Insurance- Photographs are sometimes necessary for insurance coverage.**

_____ **Office Reference- The photographs are sometimes used for educational purposes. The photos will be used without identifying information, such as name or date of birth; however, others may still be able to recognize the patient if distinctive features are photographed.**

_____ **Marketing- The discrete use of photographs may be used without identifying information on company marketing materials, including presentations, brochures, and their website. The photos will be used without identifying information, such as name or date of birth; however, others may still be able to recognize the patient if distinctive features are in the photograph.**

My signature below verifies that I have given consent for the uses that I have initialed.

_____ _____

Patient/Guardian Signature **Date**

_____

Printed Name

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X-RAY CONSENT FORM

Date: _____ **Patient Name:** _____

Date of Birth: _____

Physician: **Smith Mantha DPM**

For the office to take X-Rays, we require the patients consent before the procedure.

WHY X-RAYS ARE TAKEN?
To assist in the diagnosis of your condition. An x-ray allows us to determine if a bone may be be chipped, dislocated or broken.

To assist in the diagnosis of degenerative conditions such as Arthritis and Osteoporosis.

PREPARING FOR AN X-RAY:
You will be asked to remove any jewelry or metal objects that may obscure the image.

For your safety you will be offered a lead based apron to shield your reproductive organs from exposure to the X-Rays. The lead apron is used as a protection against the small amount of radiation you may be exposed to during the procedure.

_____ **I Request to be protected with a Lead Apron**

PREGNANCY: ***Radiation can be harmful to a growing fetus in high doses. It is important to inform the technologist if you are or think you may be pregnant The doctor may choose to forgo the X-ray, or additional steps will be taken to reduce the risk of exposure.***

_____ **I AM PREGNANT** _____ **I AM NOT PREGNANT** _____ **I COULD BE PREGNANT**

I UNDERSTAND THAT MY DOCTOR MAY NEED X-RAYS TO DIGNOSE MY CONDITION

_____ **I GIVE PERMISSION FOR X-RAYS TO BE TAKEN**

_____ **I REFUSE PERMISSION FOR X-RAYS TO BE TAKEN**

_____ _____

Patient/Guardian Signature **Date**

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AUTHORIZATION TO RELEASE RECORDS

Patient: _____ **SS# (Last Four Digits):** _____

Phone: _____ **DOB:** _____

To: _____

_____

_____

Phone: _____

Fax: _____

I hereby authorize and request the release of

☐ **ALL medical records and correspondence in my file.**

☐ **The following records only** _____

Please Send Records To:
Advantage Foot Care of Houston Fax: 832-369-1761
email: doctor.mantha@gmail.com

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Witness Signature **Date**

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ACKNOWLEDGMENT RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have access to a copy of the office's Notice of Privacy Practices.

Patient/Guardian Signature

Date

Printed Name