Dr. Gary Heredia
Dr. Morgan Zellers
3550 Parkwood Blvd Ste 702
Frisco, TX 75034
o: 972-559-0051
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WELCOME TO STAR FOOT & ANKLE SPECIALISTS

PATIENT INFORMATION

Name: _____ **Date:** _____
LAST FIRST MI

Date of Birth (DOB): _____ **Age:** _____ **Sex:** _____ **Social Security #:** _____

Home Address: _____
STREET CITY STATE ZIP

Home Phone: _____ **Mobile #:** _____

Email: _____

Primary Physician: _____ **DATE OF LAST EXAM:** _____

Primary Physician Phone Number: _____

PREFERRED PHARMACY INFORMATION:

Pharmacy Name: _____ **Phone Number:** _____

Pharmacy Address: _____
Street City State ZIP

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Hawaiian/Pacific Islander ☐ White
☐ Other: _____ ☐ Decline to answer

Ethnicity: ☐ Not Hispanic / Latino ☐ Hispanic / Latino ☐ Other: _____ ☐ Decline to answer

Primary Language: _____ ☐ Decline to answer

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

EMPLOYMENT: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Student

Employed By: _____ **Work Phone:** _____ **Ext:** _____

Work Address: _____

REFERRED BY: ☐ Doctor: _____ ☐ Patient/Friend: _____

☐ Insurance ☐ Online Search ☐ Social Media ☐ Other: _____
(Facebook, Google Reviews, Yelp, etc.)

INSURANCE INFORMATION

Primary Medical Insurance: _____

ID/Member #: _____ Group/Policy #: _____

Secondary Insurance: _____

ID/Member #: _____ Group/Policy #: _____

RESPONSIBLE PARTY (SELF / NAME OF PERSON INSURANCE IS CARRIED BY OR PRIMARY CARRIER OF THE INSURANCE)

Name of Insured (if other than patient): _____

Date of Birth: _____ Age: _____ Social Security: _____

Employed by: _____Work Phone: _____

Address if different from patient: _____

Spouse (Parent) Name: _____ Spouse (Parent) DOB: _____

Spouse (Parent) Occupation: _____ Spouse (Parent) Phone #: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____ Home phone: _____

Address: _____
STREET CITY STATE ZIP

Cell #: _____ Work #: _____ Ext_____

Consent for Treatment

I hereby consent to evaluation, diagnostic procedures, testing and treatment as directed by my physician or his/her designee. I understand that this consent to treat will be valid for each visit I make to FRISCO Foot & Ankle Specialists, until revoked by me in writing. By signing below, I understand and agree to all stated and filled in above.

_____ _____
Signature of Patient / Guardian or Patient Representative Date

_____ _____
Printed Name of Patient / Guardian or Patient Representative Relationship to Patient

Frisco FOOT & ANKLE SPECIALISTS

MEDICAL INFORMATION

Patient Name: _____ **DOB:** _____

Reason for visit today: _____

Duration? _____ days; _____ weeks; _____ months; _____ years **R or L Foot?** _____

Was this a result of an accident at work or auto accident? ☐ Yes ☐ No **If yes, date of injury** _____

Have you tried any prior treatment? _____ **By Whom?** _____

Former Podiatrist: _____

Have you had any other problems with your feet or ankles? _____

Have you had any operations (surgery) on your feet or ankles? _____

GENERAL HEALTH INFORMATION:

Weight: _____ **Height:** _____ **Current Shoe Size/Width:** _____

Do you have diabetes?

☐ Yes ☐ No **If yes, do you take insulin?** ☐ Yes ☐ No **If yes, number of Years** _____

Most Recent A1C value: _____ **Date of last A1C:** _____

Have you had any surgeries? ☐ Yes ☐ No. **If yes, what:** _____

_____

Are you currently under the care of any other physician? ☐ Yes ☐ No. **If yes, for what problem(s)?**

_____

Tobacco/Nicotine (includes vaping) use? ☐ Yes ☐ No **If yes, amount/number of packs per day:** _____

Number of years: _____ **If you quit using tobacco, how long ago?** _____

Do you drink beer, wine or alcohol? ☐ Yes ☐ No. **If yes,** ☐ <1 Drink a day ☐ 1-2 Drinks a day ☐ >3 Drinks a day

Do you work? ☐ Yes ☐ No. **If yes, what type of job:** _____

At your job, do you: ☐ sit most of the time ☐ stand most of the time ☐ stand and walk.

Does your employer require you to wear certain shoes at work? ☐ Yes ☐ No. **If yes, what kind?** _____

Please list all medications you take: _____

_____

_____

ALLERGIES or ALLERGIC REACTION to:

- ☐ Penicillin
- ☐ Sulfa
- ☐ Iodine (Betadine or dye)
- ☐ Keflex
- ☐ Tetracycline
- ☐ Darvon / Darvocet
- ☐ Erythromycin
- ☐ Aspirin
- ☐ Anti-inflammatory (Naprosyn, Advil, Motrin, Aleve, et)
- ☐ Codeine
- ☐ Morphine or Demerol
- ☐ Local anesthesia
- ☐ Adhesive tape; Band-aids
- ☐ Latex
- ☐ Other(s):

_____

_____

_____

_____

Do you have any artificial joint(s) or heart valve: ☐ **Yes;** ☐ **No. If yes, where:** _____

Are you pregnant or breastfeeding: ☐ **Yes;** ☐ **No**

PAST or PRESENT MEDICAL HISTORY:

- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Keloid Formation
- ☐ Legal Blindness
- ☐ Low Back Pain
- ☐ Neuropathy
- ☐ Open Wounds
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Stomach Ulcers/GERD
- ☐ Tuberculosis
- ☐ Other/Details: _____

_____

_____

EXPERIENCING ANY OF THE FOLLOWING RECENTLY:

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Fever
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Chills
- ☐ Difficulty Breathing
- ☐ Calf Pain
- ☐ Dizziness
- ☐ Headaches
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Leg Swelling
- ☐ Neck Pain
- ☐ Other: _____
- ☐ Tingling or numbness
- ☐ Weight Gain
- ☐ Weight Loss

FAMILY HISTORY:

Mother: ☐ **Living** ☐ **Deceased; Cause of death:** _____ **Age:** _____

Father: ☐ **Living** ☐ **Deceased; Cause of death:** _____ **Age:** _____

Brother: ☐ **Living** ☐ **Deceased; Cause of death:** _____ **Age:** _____

Sister: ☐ **Living** ☐ **Deceased; Cause of death:** _____ **Age:** _____

Family (blood relative) Medical History:

- ☐ Arthritis
- ☐ Heart disease
- ☐ Bleeding disorders
- ☐ Sickle Cell
- ☐ Diabetes
- ☐ Flat feet
- ☐ Flat Feet
- ☐ Gout
- ☐ Bunions
- ☐ Neurologic Disorders
- ☐ Hammertoes

The above information is accurate to the best of my knowledge:

_____ _____

Signature **Date**

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Financial Policy

Payment is required for all services at the time they are rendered. As a courtesy we will file your claim with your insurance carrier. Applicable co-payments, estimated deductibles, coinsurance and non-covered services will be collected. Once our office has received an "Explanation of Benefits" from your insurance, and the provider adjustments have been applied, you will receive a statement for any outstanding balance, which is due upon receipt. In the event an overpayment has been made and to ensure the most accurate refund amount, please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.

If you are a member of a plan in which you must choose a "primary care physician", it is your responsibility to obtain a referral from the PCP prior to your appointment with Star Foot & Ankle Specialists. If you have not done so, your visit may not be covered, and you will be responsible for payment in full at the time of service or you may choose to reschedule your appointment.

We accept payment in the form of cash, check, and all major credit cards. If a check is returned to our office, there will be a $35.00 return check fee added to your account. Please note that all future appointments will need to be paid with cash, credit card or money order only. For appointments which are missed or cancelled with less than 24-hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make, in-full, prompt payment to Doctors of Internal Medicine when billed for, any and all, charges not covered or paid by valid insurance benefits for services rendered. Further, I authorize payment directly to Doctors of Internal Medicine for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Patient Signature **Date**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that providers amore complete description of the uses and disclosers of certain Health Information. I understand that FRISCO Foot & Ankle Specialists, reserve the right to change their Notice of Privacy Practices and prior to implementation will post a copy in the office. I have the right to request a copy at any time.

_____ _____ _____
Patient Name (please print) **Date**

_____ _____
Printed Name of Patient / Guardian or Patient Representative **Relationship to Patient**

_____
Signature

☐ **I hereby give my permission to Dr. Gary Heredia, DPM and Dr. Morgan Zellers, DPM to disclose and discuss any information related to my medical condition(s) to / with the following family member(s), other relatives and / or close personal friends:**

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

☐ **I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition.**

_____ _____
Signature **Date**

Authorization for Photo/Video

_____ **I, hereby acknowledge that FRISCO Foot & Ankle may take photos or videos of my foot. Pictures/videos will be of**
Initials **my condition, treatment of condition and progress of my treatment. This may be used on social media or for future training within the practice. Not at any time will my face, name, date of birth or any identifying features will be show, listed, or displayed**

Authorization For Communication & Voicemails

At FRISCO Foot & Ankle Specialists, we do our best to reach you via phone regarding any issues that may arise. Unfortunately, there may be times that we are unable to reach you and we may need to communicate with you by other means than a phone call. Please provide us with other means of communication:

_____ ☐ **Yes, Leave Detailed Message** ☐ **No, I Decline for detailed messages to be left**
Initials **Please Leave detailed messages on the following:** _____ _____
Primary Phone Number **Secondary Phone Number**

_____ ☐ **Yes, I want to receive text messages** ☐ **No, I Decline text messages**
Initials **Please send text messages to the following:** _____
Cellphone Number

_____ ☐ **Yes, I want to receive Emails** ☐ **No, I Decline emails (No results or PHI are sent thru email)**
Initials **Please email regarding upcoming appointments or general clinic communications to: (This will also be the email the office will use to send you an invite to our patient portal).**

_____ _____
Signature **Date**