Jaret D. Walker, DPM
Podiatric Medicine and Surgery
3205 MedPark Drive
Denton, Texas 76208
Office: (940) 382-8400
Fax: (800) 345-5821

Patient Information

First Name _____ Middle Initial _____ Last _____

Address _____ City _____ State ____ Zip _____

Sex _____ Date of Birth ____ / ____ / _____ Email _____@_____

Home Phone (_____) _____ Cell Phone (_____) _____

Social Security # _____ - ____ - _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer _____ Work Number (_____) _____

How did you find Dr. Walker? ☐ Our Website ☐ Insurance Co ☐ Family/Friend ☐ Newspaper _____

☐ Dr. _____ ☐ Phone Book, which one? _____ ☐ Other _____

Emergency Contact

Name _____ Sex _____ Date of Birth ____ / ____ / _____

Phone (_____) _____ Relationship _____

I certify that all information contained in this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____*

Guarantor or Responsible Party (if not same as above)

First Name _____ Last _____

Relationship _____ Sex _____ Date of Birth: ____ / ____ / _____

Home Phone (_____) _____ Cell Phone (_____) _____

Address _____ City _____ State ____ Zip _____

Co-pays, deductibles and all co-insurance payments will be expected at time of service. We will file your insurance claim as a courtesy to you.

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Name _____ Age _____

Describe your foot problem _____

_____

How long has it bothered you? _____ If an injury/accident, where did it occur? _____

Which foot or ankle? ☐ LEFT ☐ RIGHT ☐ BOTH

Do you have any swelling in the area? ☐ YES ☐ NO Is your problem painful? ☐ YES ☐ NO

When does it hurt? ☐ SITTING ☐ WALKING ☐ EXERCISING

Today compared to the start of the problem, is it? ☐ BETTER ☐ WORSE ☐ SAME

What treatment have you tried at home? ☐ ICE ☐ REST ☐ MEDS ☐ CHANGE SHOE GEAR

Is your pain? ☐ CONSTANT ☐ SOMETIMES What is your pain level on a scale of 1-10 (10 the worst)? ____

List anything that has helped your problem _____

List anything that makes your problem worse _____

List any past foot or ankle problems _____

List any past surgical procedures on your feet or ankles _____

Shoe Size _____ Weight _____ Height _____

GENERAL HEALTH INFORMATION

HEART PROBLEMS: ☐ Clogged Arteries ☐ Pace Maker ☐ CHF ☐ Mitral Valve Prolapse ☐ Rheumatic
☐ Bacterial Endocarditis ☐ Murmur

☐ Diabetes, circle treatment: ☐ Pill ☐ Insulin ☐ Both
How many years have you been diabetic? _____ Typical blood sugar reading in a.m.? _____

☐ Arthritis If you do have Arthritis, where? _____

☐ Asthma If you do have Asthma, are you sensitive to Aspirin? ☐ YES ☐ NO

☐ Lung	☐ Anemia	☐ Cholesterol	☐ Dementia	☐ Bipolar
☐ High Blood Pressure	☐ Bleeding Disorder	☐ Lyme Disease	☐ Depression	
☐ Low Blood Pressure	☐ HIV or AIDS	☐ ADHD or ADD	☐ Anxiety	
☐ Kidney	☐ Hypothyroid	☐ Lupus	☐ Acid Reflux	
☐ Liver	☐ Hyperthyroid	☐ Raynaud's	☐ Crohn's Disease	
☐ Hepatitis	☐ Tuberculosis	☐ Fibromyalgia	☐ Gastritis	

☐ Cancer ☐ Active ☐ Remission Type and YEAR diagnosed? _____

☐ History of Blood Clot How many years ago? _____ Where & Why? _____

☐ Gout Where? _____ ☐ Seizures When was your last one? _____

☐ Heart Attack When? _____ ☐ Stroke When? _____

☐ History of Skin Ulcer Where? _____

List any MEDICAL PROBLEMS not found in the list above _____

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Do any of the following **FAMILY** members (Mother, Father, Brother, Sister, Daughter, Son) suffer from the medical problems listed below? Please list the family member(s).

☐ Heart Disease _____ ☐ Diabetes _____

☐ Arthritis _____ ☐ Problems with General Anesthesia _____

☐ Flat feet _____ ☐ Amputations _____

☐ Cancer _____

List any Current Medications you are taking, including vitamins _____

_____

_____

List any allergies to medications _____

List any previous surgeries and the year _____

_____

_____

Family Physician _____ Date of your last appointment _____

☐ Retired ☐ Disabled ☐ Working, describe your job _____

Do you smoke? ☐ YES ☐ NO How many packs per day? _____ How many years? _____

Do you have a history of smoking? ☐ YES ☐ NO What year did you stop smoking? _____

Do you chew tobacco? ☐ YES ☐ NO Do you suffer from any drug dependency? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO Have you ever been or are you currently an alcoholic? ☐ YES ☐ NO

Do you exercise? ☐ Regularly ☐ Never

Do you **currently** or have you **recently** had any of the following symptoms?

☐ Drastic change in WEIGHT	☐ Sore THROAT	☐ Easy BLEEDING
☐ FEVER	☐ Difficulty BREATHING	☐ Pain with URINATION
☐ General FATIGUE	☐ Persistent COUGH	☐ Blood in URINE
☐ Change in SKIN color	☐ Coughing Blood	☐ Frequent Urination
☐ Change in a RASH	☐ CHEST pain	☐ GOITER
☐ Change in a MOLE	☐ CHEST Palpitations	☐ HEADACHES
☐ Blurry VISION	☐ Limb Swelling	☐ Double VISION
☐ Dry EYES	☐ Decrease in APPETITE	☐ BALANCE PROBLEMS
☐ EYE pain	☐ Blood in or Black STOOLS	☐ DEPRESSION
☐ EAR ringing	☐ Nausea or Vomiting	☐ ANXIETY
☐ Dizziness	☐ Easy BRUISING	☐ Slow HEALING

Pain or Stiffness in your ☐ Neck ☐ Back ☐ Shoulders ☐ Wrist ☐ Hands ☐ Hips ☐ Knees

I certify that the information contained in this form is true & correct to the best of my knowledge.

Signature: _____ Date: _____

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Financial Arrangements, HIPAA, and Medical Insurance

Medicare Patients:
Since Dr. Walker is a participating provider under Medicare, we will file your claims, accept assignment, and apply your co-pay. Unless secondary insurance information is provided, we will request that your portion (or uncovered charges) be paid at the time of service or within 30 days of notice by Medicare of your balance. Federal law requires that your portion of the services provided equals 20% co-pay and any unmet deductible.

Traditional Insurance Plans:

1. Your insurance contract is between you and your insurance company. We are allowed to participate within the terms of our contracts with the HMO/PPO.
2. Our service and procedure fees are comparable with the usual and customary charges of Denton County. Not all services are covered by all insurers, thereby creating charges that would become the patient/guarantor's responsibility. Should you have any questions concerning your charges please speak to the office staff.
3. It is imperative that you inform our office of any change in address, employment, or insurance, so your chart will remain accurate.
4. It will be necessary to collect your portion (co-pay, deductibles) of the responsible charges.
5. Documentation of each visit and any service provided will be performed. We will use this information to bill your primary insurance carrier on their required insurance claim form.
6. Any services not paid within 60 days of the claim filing will default to the patient/guarantor's responsibility.

Assignment of Insurance Benefits
In consideration of medical services rendered or to be rendered, I hereby irrevocably assign to Dr. Jaret Walker and Advanced Foot and Ankle Surgery all rights, title, and interest in the benefits payable to said services rendered. Said irrevocable assignment and transfer shall be the recovery on said insurance policy, but shall not be construed to be an obligation of this practice to pursue any such rights of recovery. This assignment shall not take away the patient/guarantor's standing to make claim or sue for benefits individually should coverage be denied by insurance carrier(s). I hereby authorize the insurance company(ies) to pay Advanced Foot and Ankle Surgery and or Dr. Walker all benefits due under said policy(ies) for services rendered. I understand that I (patient/guarantor) am responsible for any services not covered by my insurance company(ies). A Photostat copy of this form shall be considered as effective and valid as the original.

If a bill owed by the guarantor is not paid and the debt is turned over to a collection agency, a $50 fee will be added to the amount previously owed. If a check is returned for insufficient funds, a $30 fee will be added to the amount previously owed.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

LIST any person's name you will allow us to discuss your health information with. Examples—wife, son, healthcare facilities, etc. Please write their FULL NAME(S).

_____

By signing below I agree to BOTH the FINANCIAL AGREEMENT in the first section of this document and agree to the PROTECTED HEALTH INFORMATION including $30 and $50 added fees if applicable.

_____

Print Name of Patient Signature Patient or Legal Representative Date