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 _____

Apartment/Lot # _____ Sex _____ Date of Birth ____ / ____ / _____

Patient REFUNDS and STATEMENTS will be sent to the above address.

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

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

Preferred Pharmacy

All prescriptions are sent electronically to your preferred pharmacy.

Name _____ Address _____

City _____ Phone _____

Emergency Contact

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

Phone (_____) _____ Relationship _____

Co-pays, deductibles and all co-insurance payments will be expected at time of service.

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Name _____ Age _____

Describe your foot problem

How long has it bothered you? _____days _____ weeks ____ months_____ years

If an INJURY or ACCIDENT, where did it occur? _____

What bothers you? ☐ FOOT ☐ ANKLE ☐ TOENAIL Which foot? ☐ LEFT ☐ RIGHT ☐ BOTH

Do you have any **SWELLING** in the area? ☐ YES ☐ NO Is your problem **PAINFUL**? ☐ YES ☐ NO

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 ☐ ICE ☐ REST ☐ MEDS ☐ CHANGE SHOE GEAR ☐ SOAKING

List anything that makes your problem **WORSE** ☐ WALKING ☐ RUNNING ☐ REST ☐ PRESSURE

List any past foot or ankle problems & surgeries ☐ NEUROMA ☐ PLANTAR FASCIITIS ☐ BUNION

☐ INGROWN TOENAIL ☐ SPRAIN ☐ FUNGUS ☐ NEUROPATHY ☐ SURGERY ☐ AMPUTATION

Shoe Size: **Weight:** **Height:**

GENERAL HEALTH INFORMATION

HEART PROBLEMS: ☐ Clogged Arteries ☐ Pace Maker ☐ CHF ☐ Heart Attack

☐ Diabetes, check treatment: ☐ Pill ☐ Insulin ☐ Both

How many years have you been diabetic? _____ Typical blood sugar reading in a.m.? _____

☐ Asthma

☐ Arthritis	☐ Stroke	☐ Seizure
☐ History of Skin Ulcer	☐ Anemia	☐ Cholesterol
☐ High Blood Pressure	☐ Bleeding Disorder	☐ Dementia
☐ HIV or AIDS	☐ ADHD or ADD	☐ Mental Illness
☐ Kidney	☐ Hypothyroid	☐ PVD
☐ History of Blood Clot	☐ Gout	☐ Venous Insufficiency
☐ Hepatitis	☐ Tuberculosis	☐ Cancer _____

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?

☐ Heart Disease	☐ Diabetes
☐ Arthritis	☐ Problems with General Anesthesia
☐ Flat feet	☐ Amputations
☐ Cancer	☐ Adopted

List any current **MEDICATIONS** you are taking

List any **ALLERGIES** to medications

List any previous **SURGERIES**

Family Physician _____

Are you currently on **Hospice Services** ☐ YES ☐ NO Are you receiving **Home Health Care** ☐ YES ☐ NO

☐ **Retired** ☐ **Disabled** ☐ **Working**, describe your job _____

Do you **SMOKE**? ☐ YES ☐ NO Do you have a **HISTORY OF SMOKING**? ☐ YES ☐ NO

Do you suffer from any **DRUG DEPENDANCY**? ☐ YES ☐ NO Do you drink **ALCOHOL**? ☐ YES ☐ NO

Have you ever been or are you currently an **ALCOHOLIC**? ☐ YES ☐ NO Do you **EXERCISE**? ☐ YES ☐ NO

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

Primary Doc Insurance Pharmacy

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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-insurance. Unless secondary insurance information is provided, we will request that your portion (or uncovered charges) be paid at the time of service. Federal law requires that your portion of the services provided equals 20% co-insurance 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. Any services not paid within 60 days of the claim filing will default to the patient/guarantor's responsibility.

The Patient/Guarantor is responsible for any services not covered by insurance.

A $50 fee will be added to the amount previously owed if we must turn to a **COLLECTION AGENCY** to recoup money owed us.
A $30 fee will be added to the amount previously owed for any **RETURNED CHECKS** written to us.

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 you agree to BOTH the FINANCIAL AGREEMENT and to the PROTECTED HEALTH INFORMATION including $30 and $50 added fees if applicable.

_____

Name of Patient (PRINT) Patient or Legal Representative (SIGN) Date