Family Foot Care

DR. GERALD B. McCOOL

PODIATRIC PHYSICIAN & SURGEON

DATE_____

PATIENT REGISTRATION

6955 N. Mesa, Suite 301, El Paso, TX 79912
(915) 581-1133 • Fax (915) 581-9656

PATIENT INFORMATION

Email:_____ / Invite access to pt portal ❒ Y ❒ N

Last Name: _____ First Name: _____ MI: _____

Sex: ❒M ❒ F Date of Birth: _____/_____/_____

Financial Responsible Party _____ Relationship:_____ Phone:_____

Marital Status: _____ Referring:_____

Social Security No:_____ Home Phone:_____ Cell:_____

Home Address: _____ Work Phone: _____ Ext.:_____

Mailing Address:_____ City:_____ State:_____ Zip Code:_____

Please name a designated person, you give to change/make/cancel appts., discuss account information, share clinical information, in case of emergency contact.

Name:_____ Phone:_____ Relationship:_____

PLEASE PROVIDE YOUR INSURANCE CARD AND A VALID PICTURE ID TO THE RECEPTIONIST

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. McCool to release any medical and/or demographic information acquired in the course of my treatment necessary to process insurance claims.

I hereby give Dr. Gerald B. McCool and/or whomever he may designate as his assistant permission to examine and treat my feet and photograph any work he does providing it be used for medical or educational purpose.

I acknowledge that Dr. McCool's office is in compliant with the HIPPA Privacy Rules and I have given the opportunity to read the notice of Privacy Practices, which is posted in the office. I have the right to receive a copy of this notice of Privacy Practices upon request by me to Dr. Gerald B. McCool.

_____
SIGNATURE (Patient or Parent if Minor)

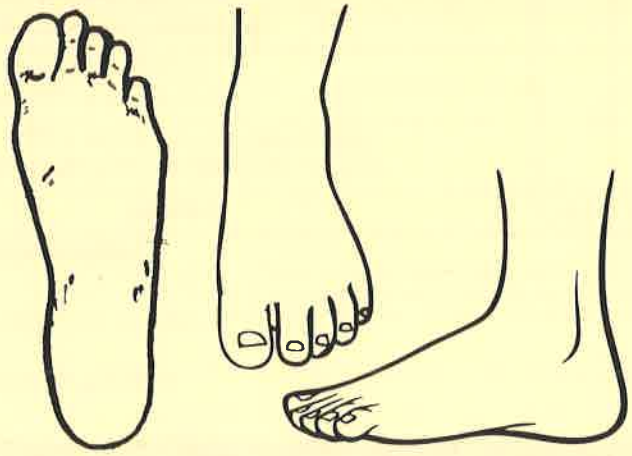
_____
Date

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance. I understand that I am fully responsible for any and all charges not covered by insurance carrier. I understand that all payments must be paid at the time of service.

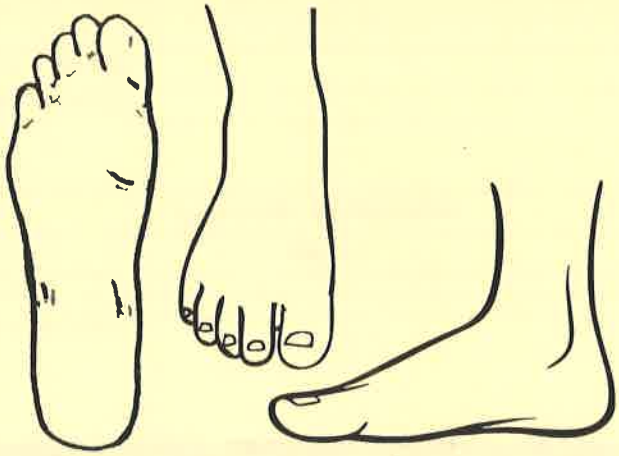
_____
Signature **Date**

PLEASE MARK THE DIAGRAM WHERE YOU HAVE FOOT PROBLEMS

LEFT FOOT & ANKLE



RIGHT FOOT & ANKLE



HEALTH HISTORY

Referring Physician: _____

Primary Care Physician: _____ When last seen: _____

PATIENT NAME:			DATE:
Question	**YES**	**NO**	**Comments / Explanation**
Do you have an advanced care plan or surrogate decision maker (living will)?			
Are you a tobacco user?			How frequent?
Do you drink alcohol?			How frequent?
Drug allergies? (please list)			
Latex/rubber allergies?			
Other known allergies? (please list)			
Other abnormal drug reactions? (Explain)			
Are you **diabetic**? Pills / Insulin / Diet			
Is your diabetes **diet controlled**?			
Mobility impairments?			
Disabilities? (Explain)			
Heart Trouble?			
High Blood Pressure?			
Leg Cramps?			
How far can you walk?			
Burning, numbness or tingling of feet?			
Swelling of legs or feet?			
Do your feet hurt?			
Do you have hypoglycemia? (Low Blood Sugar)			
Skin problems/swelling of feet & ankles?			
Have you or anyone in your family had an unusual reaction to anesthesia such as high temp, difficulty waking up, nausea and/or vomiting?			
Surgery History			
Procedure:			Date
Procedure:			Date
Procedure:			Date
Do you have any **implants or prostheses**?	**YES**	**NO**	Date
Type:			Location: Date
Current medications (herbal, prescribed, over-the-counter, steroids, diet pills, other)	**YES**	**NO**	If yes, please include name/dosage/how often
1.			Dosage:
2.			Dosage:
3.			Dosage:
4.			Dosage:
5.			Dosage:
6.			Dosage:
7.			Dosage:
8.			Dosage:
9.			Dosage:
10.			Dosage:
Have you had prior treatment from another podiatrist?	YES	NO	For what? When:

_____

Signature Date