



10114 HUEBNER RD. SAN ANTONIO, TX. 78240  
PH 210-477-3668 FAX 210-558-0868

### INSURANCE INFORMATION

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD AND GOVERNEMENT ISSUED PHOTO ID

Patient Name: Last \_\_\_\_\_ MI \_\_\_\_\_ First \_\_\_\_\_  
Today's Date \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F  
Home Phone ( ) \_\_\_\_\_ Mobile( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_  
Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Apt# \_\_\_\_\_ Zip \_\_\_\_\_ SocialSecurity# \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Married Spouse: Employed? Yes or No Single Divorced Widowed  
Emergency Contact:  
Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

If the above patient is a minor, has legal guardian, list responsible party below:

Name: Last \_\_\_\_\_ MI \_\_\_\_\_ First \_\_\_\_\_  
SocialSecurity# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F  
Home Phone ( ) \_\_\_\_\_ Mobile ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Apt# \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Primary Insurance: (**Medicare is primary only** if your spouse is **NOT** employed)

Insurance Company: \_\_\_\_\_ Effective date \_\_\_\_\_  
Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Insured Name: Last \_\_\_\_\_ MI \_\_\_\_\_ First \_\_\_\_\_  
Insured Social Security \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_

Secondary Insurance Information:

Insurance Company: \_\_\_\_\_ Effective date \_\_\_\_\_  
Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Insured Name: Last \_\_\_\_\_ MI \_\_\_\_\_ First \_\_\_\_\_  
Insured Social Security \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

I authorize payment of medical benefits to undersigned physician or supplier for services described.

\_\_\_\_\_  
Signature (Insured or authorized person)

\_\_\_\_\_  
Date



If you are age 17 – 27, are you a full-time actively enrolled student?

N/A

YES

NO : please explain \_\_\_\_\_

Name of your primary physician/medical provider:

Last \_\_\_\_\_ First \_\_\_\_\_

(If you have Medicare or Tricare, these companies require the name of your physician for processing your insurance claim)

For Military:

N/A

Which facility do you seek most of your medical treatment:

WHMC    BAMC    RAFB

If you are diabetic, please name your diabetes doctor:

N/A

Last \_\_\_\_\_ First \_\_\_\_\_

How were you referred to our office?

Medical Provider Name \_\_\_\_\_

Friend or Family Name \_\_\_\_\_

My insurance website \_\_\_\_\_

Yellow pages

Driving by office/location

The Internet: please name search site (i.e. yahoo, Google, etc..) \_\_\_\_\_

Other \_\_\_\_\_

### **Release of Information**

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

\_\_\_\_\_  
Signature (Insured or authorized person)

\_\_\_\_\_  
Date



Please respond to the following questions to better evaluate your problem.

Where is the location of problem? Right Foot Ankle Toe #\_\_\_\_\_

Left Foot Ankle Toe #\_\_\_\_\_

How long has the pain been present? \_\_\_\_\_

Please circle the number that best represents your pain level.

1 2 3 4 5 6 7 8 9 10

less severe

more severe

Type of pain: Aching / Tingling / Numbness / Sharp / Stabbing / Burning

What makes the pain better: \_\_\_\_\_

What makes the pain worse: \_\_\_\_\_

Have you been treated by another physician for this problem? Yes  No

Physician's name: \_\_\_\_\_

Describe the treatment: \_\_\_\_\_

The problem is a result of:  Work Accident  Car Accident  Sport Injury  
 Other Injury date \_\_\_\_\_

Have you submitted a claim with Worker's compensation or any other type of claim due to your problem? Yes  No

Do you have legal representation related to your problem? Yes  No

Please provide the name and phone number of your attorney, if applicable.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

*Knowingly falsifying the above information is against the law, even if it is with the advice from your attorney.*

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact, commits a fraudulent act, which is crime subject to criminal prosecution and civil penalties.

\_\_\_\_\_  
Signature of Patient, Representative, or Guardian (if minor)

\_\_\_\_\_  
Date



In the following table, please list any medical conditions (such as high blood pressure, diabetes, etc.) and the medication(s) you take for that problem.

MEDICAL PROBLEM	MEDICATION	DOSE/FREQUENCY

Please list any allergies below. Include medications, latex, food, tape, shellfish, etc.

ALLERGY TO	REACTION

Please list all surgeries below.

TYPE OF SURGERY	DATE

Have you ever had a problem with anesthesia?  Yes  No If yes, explain below:

\_\_\_\_\_

\_\_\_\_\_

Please list your family history of diseases below.

FAMILY MEMBER	ALIVE (YES OR NO)	DISEASE HISTORY
Mother		
Father		
Brother/Sister		
Brother/Sister		
Brother/Sister		
Grandmother (mother's side)		
Grandmother (father's side)		
Grandfather (mother's side)		
Grandfather (father's side)		



Occupation: \_\_\_\_\_  
 Do you exercise?  Yes  No If yes, how often do you exercise: \_\_\_\_\_  
 What type of activities/exercises you enjoy: \_\_\_\_\_  
 Do you have a special diet?  Yes  No Describe: \_\_\_\_\_  
 Do you drink alcohol?  No  Yes # Drinks per week: \_\_\_\_\_  
 Do you smoke?  No  Yes # Packs per day: \_\_\_\_\_  
 Quit smoking? \_\_\_\_\_ years of smoking previously  
 History of substance abuse?  No  Yes if yes, please explain: \_\_\_\_\_

**Review of Systems:** Do you have any problems with the following? Please mark yes or no and describe all yes responses.

Problem	Yes	No	Describe all Yes responses
Heart: palpitations, chest pain, irregular heart beat			
Fever/chills/appetite change			
Ear, Nose, Throat			
Bleeding problems			
Eyes			
GI/Digestion problems: nausea, heartburn, vomiting			
Urinary problems			
Psychological problems			
Bone/joint/muscle problems			
Breathing/lung problems			
Skin disorders/rashes			
Fainting/dizziness			
Loss of balance/numbness			

Please describe any other problems you may be experiencing in the space below:

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