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INSURANCE INFORMATION

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD AND GOVERNMENT 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 _____



Pharmacy Name: _____ Phone: _____
Cross streets: _____ Mail Order Pharmacy: _____

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: _____

Race/Ethnicity (please circle): African-American Asian Caucasian Hispanic
 Other: _____

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:

Preferred language (please circle): English Spanish Other: _____
