New Patient Information

Patient Name_____ Date of Birth_____ Age_____

Marital Status_____ Social Security #_____ Sex_____

Home Phone: _____Cell Phone: _____

Address, City, Zip:_____ Email_____

Employer_____ Work Phone & Ext_____

Emergency Contact_____ Daytime Phone #_____

Relationship to patient_____ Referred By_____

Any contact restrictions? _____

Do you have a legal guardian or healthcare power of attorney? Yes or No
If yes, Name _____ Relationship _____ Phone # _____

I, _____ authorize Advanced Foot & Ankle Center of Texarkana, P.A. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

Patient Signature: _____Date_____

Responsible Party Signature: _____Date_____
(If patient is under 18)

Policy Holder Name_____ Date of Birth_____
I give my permission to Philip J. Hahn Jr., DPM, his associates and assistants to examine and treat my feet and/or ankles. I authorize Dr. Hahn and his staff to release any medical records to my insurance company if this is required. I understand that I am financially responsible for the services rendered.

Patient Signature: _____Date_____

Responsible Party Signature: _____ Date_____
(If patient is under 18)

Request for Paperwork/Medical Records:

If you anticipate filing on a disability or any other benefit claim and require paperwork from this office, there will be a $10 fee for one page and a $25 fee for two or more pages of paperwork to be filled out for each company.
Payment will be due at time of service.
Patient Signature: _____ Date:_____

Are you currently off work while under the treatment of care of another physician? Y__ N__
If so, you will need to continue under that physician's care until you are released to return to work.

Signature: _____ **Date:** _____

PATIENT HISTORY

Name_____ _____ **Date** _____

What is the primary reason for this visit? _____

Date symptoms first occurred or injury happened _____

If injury, where did the accident occur? _____

What symptoms are you having? (pain-swelling-ect) _____

Has another doctor treated you for this problem? _____

What kind of treatment was done? _____

Have you treated yourself for this problem? (Advil-Aspirin-ect.) _____

Have you ever injured this area before?_____ **If so, when?** _____

Will this injury or accident be filed on Workers Compensation? _____

Are you under any type of pain management? ____ **If so, Physicians name** _____

Family Physician_____ **Date of last visit** _____

Do you smoke or have you ever smoked?_____ **If so, how much?** _____

Do you consume alcohol? _____ **If so, how much?** _____

Any illicit drug use? _____ **If so, what?** _____

Do you have any allergies to medications or foods?_____ **If so, what?**_____

_____

Current medication	**Dosage**	**Times a day**

Pharmacy name? _____

Is there anything else the doctor should be aware of? _____

How did you hear about us? ____**Physician** ____**Newspaper** ____**Phonebook Ad**
____**Friend** ____**Other**

Signature_____ **Date**_____

History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctor, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Place a mark on "Yes" or "No" to indicate if you have ever had any of the following:

Acid reflux	[] Yes [] No	Heel pain	[] Yes [] No
Alzheimer's	[] Yes [] No	Hepatitis	[] Yes [] No
Anemia/Blood disorder	[] Yes [] No	Hip pain	[] Yes [] No
Ankle edema	[] Yes [] No	History of gout	[] Yes [] No
Ankle pain	[] Yes [] No	HIV	[] Yes [] No
Anxiety	[] Yes [] No	Hyperglycemia	[] Yes [] No
Arthritis	[] Yes [] No	Hypertension	[] Yes [] No
Asthma	[] Yes [] No	Ingrown nail	[] Yes [] No
Athletes foot	[] Yes [] No	Jaundice	[] Yes [] No
Back pain	[] Yes [] No	Kidney disease	[] Yes [] No
Bipolar disorder	[] Yes [] No	Leg cramps	[] Yes [] No
Breathing difficulty	[] Yes [] No	Leg swelling	[] Yes [] No
Burning	[] Yes [] No	Memory loss	[] Yes [] No
Calluses	[] Yes [] No	Neuropathy	[] Yes [] No
Cancer	[] Yes [] No	Non healing wounds	[] Yes [] No
Cataracts	[] Yes [] No	Numbness	[] Yes [] No
Chill	[] Yes [] No	Oxygen use	[] Yes [] No
Congestive heart	[] Yes [] No	Phlebitis/blood clots	[] Yes [] No
Cpap use	[] Yes [] No	Plantar warts	[] Yes [] No
Diabetes	[] Yes [] No	Respiratory problems	[] Yes [] No
Dialysis	[] Yes [] No	Rheumatoid arthritis	[] Yes [] No
Difficulty with hearing	[] Yes [] No	Seasonal allergies	[] Yes [] No
Epilepsy/Neurological	[] Yes [] No	Seizures	[] Yes [] No
Eye or vision problems	[] Yes [] No	Sleep apnea	[] Yes [] No
Fever	[] Yes [] No	Stomach/bowel disorders	[] Yes [] No
Fibromyalgia	[] Yes [] No	Stroke	[] Yes [] No
Foot cramps	[] Yes [] No	Thick toenails	[] Yes [] No
Foot edema	[] Yes [] No	Thyroid disease	[] Yes [] No
Foot pain	[] Yes [] No	Tingling	[] Yes [] No
Glaucoma	[] Yes [] No	Ulcerations	[] Yes [] No
Headaches	[] Yes [] No	Urinary tract problems	[] Yes [] No
Heartburn	[] Yes [] No	Varicose veins	[] Yes [] No
Heart Disease	[] Yes [] No		

Please list all surgeries _____

_____

_____

Signature: _____ **Date:** _____

Financial Policy
Advanced Foot & Ankle Center of Texarkana, P.A.

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Please provide insurance cards if applicable. If you are self pay, payment is due at time of service.
- Deductibles, co-pays, coinsurance and any uncovered services are due at time of service. See explanation below.
  Deductible: The amount you pay in full each calendar year before the insurance plan begins to reimburse expenses. Each plan usually has an individual deductible and a family deductible.
  Co-Pay: A set fee you pay up front for a covered expense, typically, an office visit.
  Coinsurance: The percentage you are required to pay after your insurance pays a portion of the charges after the deductible has been met.
  If you have a secondary or supplemental insurance it may cover your coinsurance and/or deductible.
- **We will accept credit/debit cards, or cash. (NO CHECKS ACCEPTED)**
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- The adult accompanying the minor will be responsible for payment.

Please note: Charges for deductible and coinsurance are an estimate of what we believe your insurance will allow. Sometimes the allowable may vary and additional charges or a refund could apply.

I have read and understand how my physician desires to be compensated for the care I receive, and I agree to be bound by these terms. I authorize Advanced Foot & Ankle Center of Texarkana, P.A. to bill my insurance company.

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

Advanced Foot & Ankle Center of Texarkana, P.A.

Dr. Philip J. Hahn
5606 Summerhill Rd.
Texarkana, TX 75503
903-791-1222

Privacy Notice

We are required by applicable federal and state laws to maintain the privacy of your protected health information. A copy of these laws is available in our office waiting area. Health information Advanced Foot & Ankle Center of Texarkana, P.A. collects or receives about you is strictly confidential. However, if you wish information regarding your treatment to be disclosed to individuals other than yourself, please list below.

_____

Name of Person/Relationship to receive medical information regarding your treatment

_____

Name of Doctor to receive medical information regarding your treatment

Use and Disclosure of Information:

____I authorize the person(s) listed above to receive ALL HEALTH INFORMATION about appointments, treatment and/or other information pertinent to my healthcare and/or payment or my healthcare provided at Advanced Foot & Ankle Center of Texarkana, P.A.

____I DO NOT authorize the release of my healthcare information to any other parties except to me as a patient of Advanced Foot & Ankle Center of Texarkana, P.A.

REQUEST TO RELEASE MEDICAL RECORDS

This request will remain in effect throughout treatment at Advanced Foot & Ankle Center of Texarkana, P.A. and may repeatedly be released to the authorized parties listed above.

You may revoke this authorization or change the recipient by requesting a new authorization from at any time.

_____

Signature of Patient/Date Signed

"I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Advanced Foot & Ankle Center of Texarkana, P.A. will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Advanced Foot & Ankle Center of Texarkana, P.A. policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative."

Signature: _____ Date: _____

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name:_____ Date:_____

Circle "Yes" or "No":

				Test for PAD
1.	Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest?	Yes	No	☐
2.	Do you experience any pain at rest in your lower leg(s) or feet?	Yes	No	☐
3.	Do you experience foot or toe pain that often disturbs your sleep?	Yes	No	☐
4.	Are your toes or feet pale, discolored, or bluish?	Yes	No	☐
5.	Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?	Yes	No	☐
6.	Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	Yes	No	☐
7.	Have you suffered a severe injury to the leg(s) or feet?	Yes	No	☐
8.	Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	Yes	No	☐

Patient Signature:_____

Physician Signature:_____ Date :_____

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