Marcus A Baxter, DPM
412 Village Dr. Suite 300 • Murphy, TX • 75094
Telephone: 972-881-0110 • Fax: 972-633-3721

Patient Information

Date: ____/____/_____ Patient Name: _____
(FIRST) (MI) (LAST) (Suffix)

Marital Status: ☐Married ☐Never Married ☐Domestic Partner ☐Divorced ☐Separated ☐Widowed

Primary Care Doctor: _____
(NAME) (LOCATION) (PHONE NUMBER)

Pharmacy: _____
(NAME) (LOCATION) (PHONE NUMBER)

How did you hear about us?_____ Referral Source: _____

Demographics *(If you filled out our online patient form, please skip this section)*

SSN: _____ - _____ - _____ DOB: _____/_____/_____ Sex: _____

Home Address: _____ City/State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred Number: □Home □Cell □Work

Email: _____
Appointment reminders will be sent to your preferred phone number and email address

Primary Language: _____ Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Hawaiian/Pacific Islander ☐White

Emergency Contact: _____ Phone: _____
(FULL NAME) (RELATIONSHIP)

Financially Responsible Party Information *(if different than patient)*

Name: _____ Relationship: _____
(FIRST) (MI) (LAST)

Address: _____ City/State: _____ ZIP: _____

Phone: _____ Email: _____

Insurance Information

Method of payment: ☐ Self Pay ☐ Health Insurance

Primary Insured Name: _____ DOB: ____/____/_____ Relationship: _____

Primary Insurance Company Name: _____

Plan Type: ☐ HMO ☐ PPO ☐ Other: _____

Secondary Insured Name: _____ DOB: ____/____/_____ Relationship: _____

Secondary Insurance Company Name: _____

Plan Type: ☐ HMO ☐ PPO ☐ Other: _____

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Medical History *(Please check all that apply)*

☐ Acid Reflux	☐ Bronchitis/ Emphysema	☐ High Blood Pressure	☐ Polio
☐ Anemia	☐ Cancer	☐ Kidney Disease	☐ Rheumatic Fever
☐ Arthritis	☐ Diabetes Circle One: Type I Type II	☐ Liver Disease	☐ Sickle Cell Disease
☐ Asthma	☐ Fibromyalgia	☐ Low Blood Pressure	☐ Skin Disorder
☐ Back Trouble	☐ Gout	☐ Migraine Headaches	☐ Sleep Apnea
☐ Bladder Infections	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Stomach Ulcers
☐ Abnormal Bleeding	☐ Heart Disease/ Failure	☐ Neuropathy	☐ Stroke
☐ Blood Clots	☐ Hepatitis	☐ Open Sores/Wounds	☐ Thyroid Disease
☐ Blood Transfusion	☐ HIV+/ AIDS	☐ Pneumonia	☐ Tuberculosis

☐ Other: _____

Please list any **SERIOUS INJURIES** and the **year** when they occurred:

_____

_____

Please list any **SURGURIES** or **HOSPITALIZATIONS** and **when they occurred**:

_____

_____

Family History

☐ Anemia	☐ Bleeding Disorder	☐ Hepatitis	☐ PVD	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Neuropathy	☐ Cancer
☐ Asthma	☐ Gout	☐ Kidney Disease	☐ Numbness in Feet	☐ Other _____
☐ Renal Disease	☐ Heart Disease	☐ Liver Disease	☐ Poor Circulation	☐ None

Allergies *(Please check those that apply or provide a list to copy)*

☐ Adhesive Tape ☐ Codeine ☐ Local Anesthetic ☐ Seafood/Shellfish ☐ Other _____
☐ Aspirin ☐ Iodine ☐ Penicillin ☐ Sulfa

Reactions: _____

Medications *(Please check one option)*

☐ I would like FACT to import & verify medications through Surescripts and I will list OTC medications

☐ I prefer to list all my medications or provide a list (include dose and frequency):

_____

_____

Immunizations *(Please check those that apply)*

☐ Measles ☐ Mumps ☐ Tetanus ☐ Polio ☐ Influenza ☐Chicken Pox ☐ TB ☐ Pneumonia

☐ Current on all immunizations

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Currently Experiencing (Review of Systems) *(Please check all that apply)*

Constitutional	❑ Fever	❑ Chills	❑ Nausea	❑ Vomiting	❑ Other_____
Head	❑ Dizziness	❑ Fainting	❑ Headache	❑ Hearing	❑ Other_____
Respiratory	❑ Cough	❑ Shortness of Breath	❑ Difficult Breathing	❑ Sinus Infection	❑ Other_____
Genitourinary	❑ Burning	❑ Absence	❑ Excessive	❑ Kidney Stones	❑ Other_____
Gastrointestinal	❑ Constipation	❑ Diarrhea	❑ Heartburn	❑ Excessive Thirst	❑ Other_____
Cardiovascular	❑ Chest Pain ❑ Leg Cramps	❑ Varicose Veins ❑ Vascular Grafts	❑ Leg/Foot Ulcer	❑ Chest Palpitations	❑ Other_____
Musculoskeletal	❑ Arthritis ❑ Joint Pain	❑ Stiff Joints ❑ Muscle Pain	❑ Back Pain ❑ Weakness	❑ Deformity ❑ Amputation	❑ Other_____
Hematological	❑ Anemia	❑ Bleeding Issue	❑ Bleed Easily	❑ Bruise Easily	❑ Other_____
Dermatological	❑ Dryness ❑ Itching	❑ Athlete's Foot ❑ Hives	❑ Ingrown Nails ❑ Fungal Nails	❑ Moles/ Bumps ❑ Wound	❑ Other_____
Neurological	❑ Numbness ❑ Tingling	❑ Burning ❑ Pins/ Needles	❑ Fall Easily ❑ Fainting	❑ Tremors	❑ Other_____

Social History

Tobacco: Type _____ Frequency: ☐Everyday #_____ ☐Occasional ☐Former ☐Never

Alcohol: Type _____ Frequency: ☐Everyday #_____ ☐Occasional ☐Former ☐Never

Drugs: Type _____ Frequency: ☐Everyday #_____ ☐Occasional ☐Former ☐Never

Occupation: _____ Does this require heavy lifting: ☐ Yes ☐ No

How many hours a day do you spend on your feet at work? _____

What surfaces do you usually walk on at work? _____

Do others depend on you for care (children, pets, elderly)? _____

Are there steps to get into your home, how many? _____

Amount of Exercise: ☐Never ☐Rare ☐Occasional ☐Weekly ☐Several days a week ☐Daily

Types of Exercise: _____

Height: _____ Shoe Size: _____

Pregnant: ☐ Y ☐ N Expected due date: _____

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Describe the reason for your visit: _____

_____

In which foot/ankle does the problem occur: ☐ LEFT ☐ RIGHT ☐ BOTH

How long ago did this problem first start? _____ Days / Weeks / Months / Years

Did your pain/problem start: ☐ Suddenly ☐ Develop Gradually

Pain How would you Describe your pain? ☐ None ☐ Aching ☐ Burning ☐ Dull ☐ Itching ☐ Radiating ☐ Sharp ☐ Stabbing ☐ Other: _____

Please rate your pain on a scale of 0-10, with 10 being the worst pain possible: _____

What makes the pain worse? ☐ Standing ☐ Walking ☐ Resting ☐ Dress Shoes ☐ High Heels ☐ Flat Shoes ☐ Walking Barefoot ☐ Daily Activities ☐ Exercising ☐ Other: _____

Since the time your pain/problem began, has it: ☐ Improved ☐ Worsened ☐ Stayed the Same

What makes your pain/problem better? _____

History Have you seen any other doctors or had treatments for this? If so, please list them:

_____

Was there trauma/injury associated with this? ☐ Yes ☐ No Is this a work-related injury? ☐ Yes ☐ No

Describe trauma/injury: _____

Please list any other information you feel is pertinent to your pain/problem:

_____

_____

To the best of my knowledge, I have answered all questions on this form as accurately as possible. I understand that providing incorrect information on this form could be hazardous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

By signing this form, I give Foot & Ankle Consultants of Texas permission to give me medical treatment for my foot and/or ankle concerns.

- I understand I have the right to refuse any procedure or treatment.
- I understand I have the right to discuss all treatments with my foot & ankle surgeon

_____
Patient Name (Please Print)

_____ _____
Name of Parent or Legal Guardian Relationship to Patient

_____ _____
Patient/Guardian Signature Date

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Please place a check mark in the boxes below for the items in which you will provide consent.

☐ E-Prescription Consent

About e-Prescribing: This is a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy to reduce the chances of a patient obtaining an incorrect medication and improve patient safety. For this reason, Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) 2003 listed the following standards for e-prescribing:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions - provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this agreement, you agree to allow Foot & Ankle Consultants of Texas to send your prescriptions electronically, when possible.

☐ Allscripts Medication Search Consent

Our office is able to use our Electronic Medical Record system and the Surescripts service to obtain a list of your medication history. We will still verify you are currently taking all medications listed and allow you to add to the list as needed.

By signing this agreement, you agree to allow Foot & Ankle Consultants of Texas to acquire your medication history list through Surescripts, other healthcare providers, and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to the items I have marked above. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforced until revoked or changed.

_____
Patient Name (Please Print)

_____ _____
Name of Parent or Legal Guardian Relationship to Patient

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Patient/Guardian Signature Date

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FINANCIAL POLICY ACKNOWLEDGEMENT

By signing below, I understand that I am ultimately responsible for all fees incurred for professional services performed. I have read and agree to all the provisions of Foot & Ankle Consultants of Texas' financial policy (see laminated copy attached to this clipboard. If a copy has not been included, please notify our staff).

_____
Patient Name (Please Print)

_____ _____
Name of Parent or Legal Guardian Relationship to Patient

_____ _____
Patient/Guardian Signature Date

ASSIGNMENT OF BENEFITS AUTHORIZATION*

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Foot & Ankle Consultants of Texas. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. In the event insurance does not pay for the services rendered, I understand that I am financially responsible for all charges. I hereby authorize said assignee to release all medical information necessary to secure the payment.

_____
Patient Name (Please Print)

_____ _____
Name of Parent or Legal Guardian Relationship to Patient

_____ _____
Patient/Guardian Signature Date

**Insured patients are required to complete assignment of benefits authorizing insurance to remit payment to physician's office*

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been given the opportunity to read and understand Foot & Ankle Consultants of Texas' HIPAA Notice of Privacy Practices, and I understand my rights concerning my PHI. (see laminated copy attached to this clipboard. If a copy has not been included, please notify our staff).

_____
Patient Name (Please Print)

_____ _____
Name of Parent or Legal Guardian Relationship to Patient

_____ _____
Patient/Guardian Signature Date