PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____
(First) (MI) (Last)

Patient Address: _____

City: _____ State: _____ Zip Code:_____

Home phone: _____ Cellular Phone: _____

Sex: o Male o Female Marital Status: o Single o Married o Divorced o Widowed

Race: o African-American o Asian o Caucasian o Hispanic o Other:

Primary Language Spoken: _____

Patient Social Security Number: _____ *(required if Account Responsible)

Patient E-mail Address: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Subscriber Name: _____ Birth Date: _____

Policy Number: _____ Effective Date: _____

Group Number: _____

Relationship to Patient: _____

Subscriber Employer: _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Address: _____

City: _____ Phone Number: _____

Person(s) to Notify in Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

HEALTH QUESTIONAIRE

PLEASE PRINT CLEARLY (If you have any questions about the information we are requesting, please ask.)

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: (_____)_____-_____

CITY: _____DATE OF LAST VISIT: _____

HAVE YOU SEEN A PHYSICIAN ANYTIME IN THE LAST 2 YEARS? O YES O NO IF YES, FOR WHAT REASON?
_____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS? O YES O NO IF YES,
WHEN_____WHERE_____WHY_____

SURGICAL HISTORY (List Most Recent and Approximate year)
_____

CURRENT MEDICATIONS: (IF YOU HAVE A MEDICATION LIST, PLEASE GIVE COPY TO FRONT DESK)

TYPE:	PRESCRIPTION:
O Blood Thinner	_____
O Diabetes	_____
O Birth Control	_____
O Diuretic (Water Pill)	_____
O Blood Pressure	_____
O Ulcer	_____
O Antibiotic	_____
O Arthritic	_____
O Nerves	_____
O Other	_____

ALLERGIC REACTION to any of the following (nausea, rash, rapid heartbeat, etc.):

O PENICILLIN- _____
O SULFA- _____
O OTHER ANTIBIOTICS- _____
O LOCAL ANESTHETICS- _____
O ADHESIVE TAPE- _____
O BARBITUATES OR SEDATIVES- _____
O SLEEPING PILLS- _____
O IODINE- _____
O TETANUS- _____
O CODEINE- _____
O DEMEROL- _____
O LATEX- _____
O ANTI-INFLAMMATORY- _____
O OTHER- _____

MEDICAL HISTORY – PLEASE CHECK IF YOU EVER HAD OR CURRENTLY SUFFER FROM:

O Diabetes	**O** Lung Disease	**O** Varicose Veins
O Heart Ailment	**O** Tumors or Cancer	**O** Ulcer/Colitis
O High Blood Pressure	**O** Arthritis	**O** Circulatory Disorder
O Epilepsy	**O** Liver Disease	**O** Gout
O Kidney/Bladder Disease	**O** Stroke	**O** Venereal Disease
O Asthma	**O** Other _____	

Tobacco Use – PLEASE CHECK:

O Current Every Day Smoker	O Current Some Day Smoker	O Former Smoker
O Heavy Tobacco Smoker	O Light Tobacco Smoker	O Never Smoker

Your signature signifies you have answered this questionnaire to the best of your knowledge. Please inform the office staff and/or Dr. Davey Suh if there are any significant changes in your health.

DFW FOOT AND ANKLE FINANCIAL POLICY & AGREEMENT

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. **If your deductible has not been met on your initial new patient visit, we will collect a portion of the office visit ($100) plus co-payment and then submit the claim to your insurance.** Once we receive insurance payment, we will send out a statement to you for any remaining balance or issue you a refund if we over collected.
2. **INSURANCE** DFW Foot and Ankle PA will file insurance claims on your behalf. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.

   Even though insurance will be filed, you are responsible for any balance after insurance process your claim. All charges for treatment become due and payable 60 days after the date of service. This period allows sufficient time to process insurance payments and for you to make payment of any remaining balance.

   As a courtesy, DFW Foot and Ankle PA, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend you also contacting your insurance carrier and check into your coverage for DFW Foot and Ankle. Do not assume that you will not owe anything if you have more than one insurance policy.
3. **REFERRALS AND PREAUTHORIZATIONS** Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.
4. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee.
5. **SELF PAY PATIENTS:** All services are expected to be paid in full at the time of service.
6. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to DFW Foot and Ankle PA for charges not covered by the assignment of insurance benefits.
7. **ASSIGNMENT OF INSURANCE BEBEFITS:** I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to DFW Foot and Ankle. This assignment is for service rendered to me by DFW Foot and Ankle, Dr. Davey Suh. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether paid by my insurance company or not. I hereby authorize said assignee to release all information necessary to secure this payment.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

Signature: _____ Date:_____

Please do not forget the HIPPA Form on the back!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND PRIVACY PRACTICES

Patient Name:_____**Date of birth:**_____ **/** _____ **/** _____

I acknowledge that I have been provided and or offered a copy **of DFW FOOT AND ANKLE'S** Notice of Privacy Practices. This office's Privacy Practice handbook is always available to me in a binder in the lobby.

- It explains how **DFW FOOT AND ANKLE** will use my health information for the purposes of treatments, payment for my treatment, and their healthcare operations.
- The Notice also explains in detail how **DFW FOOT AND ANKLE** may use and share my health care information for other than treatment, payment, and heath care operations.
- **DFW FOOT AND ANKLE** will only use and share my health care information as required and/or permitted by law.

Phone Calls: By providing my contact information, I authorize **DFW FOOT AND ANKLE** to use the contact information provided to communicate with me and place calls to my home/cellular phone, leave voice messages, text messages and pre-recorded messages.

Involvement of Others in Care: I authorize **DFW FOOT AND ANKLE** to discuss my/the patient's health care information, medical needs, and financial information as necessary, with the people listed below. (Examples include: parents, spouse, adult children, trusted friends, etc.)

Name	Date of Birth (for identification)	Relationship	Phone #

May we contact you by phone and leave a message about your care? **Check ALL that APPLY**

Primary Phone #: _____ **Secondary Phone #:** _____

☐ Leave message with our contact number only ☐ Send text to cell
☐ Leave message with detailed information
☐ Do **NOT** leave message

Patient Financial Policy and Notice of Privacy Practices **Initials:**_____
I acknowledge receipt of the "Patient Financial Policy" and "Insurance Financial Policy".

Patient Photograph **Initials:**_____
I consent for DFW Foot and Ankle to photograph myself **or** minor for identification purposes **only**.

_____
Print Name

_____ _____
Signature of Patient/Guardian **Date**

Please do not forget the Financial Agreement on the back!