☐ **Welcome to our Practice.**
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Patient I.D. #

Please provide all information requested. If you have any questions or need any assistance, we will be glad to assist you.

Patient ➔ (I prefer to be called) ____________________

Legal Name: (first) ____________ (initial) ______ (last) ____________ **Age:** _____

Date of Birth: (mm/dd/yy) _____/_____/_____ **Social Security #:** ________-________-________ **Sex** ➔(M/F)

Home Address: ____________________

City: ____________ **State:** ____________ **Zip Code:** ____________

Telephone: (____) __________ **Work:** (____) __________ **Cell Phone:** (____) __________

Marital Status ➔ (single / married / separated / divorced / widowed) **Shoe Size:** __________

Parent / Guardian / Spouse: ____________ **Employed at:** ____________

Employment Status ➔ (full-time / part-time / temporary / unemployed / retired)

Employer: ____________ Occupation: ____________

Length of Employment: ____________ Address: ____________

City: ____________ State: ____________ Zip Code: ____________

Primary Insurance ➔

Insurance Company ____________

Name of Insured (policy holder) ____________

Policy Holder-Birthdate (mm/dd/yy) _______/_______/_______

Secondary Insurance ➔

Secondary carrier ? (yes / no)

Name of Insured ____________

Company: ____________

How were you referred to our office?

____

Name of person or referring physician..

____

Family Physician ➔

Name: ____________

Last Visit: ____________

Emergency Contact:

Should an emergency arise while in our office, please give us the name of your nearest relative/ friend not living with you…

Name: ____________ Relationship: ____________

Address: ____________ City: ____________ State: ________ Zip: ________

Telephone: (________) ____________ Additional Telephone: (________) ____________

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

____________________ ____________
Signature Date

____________________ ____________
Patient Name or Authorized Representative (Print) Date

Welcome to Our Practice

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Patient Name: ____

We are pleased that you have chosen us for your healthcare needs. We take pride in our practice and we are here to help you in any way that we can. We are committed to providing you with the finest care available. Our office has policies that each of our patients should be aware of. We ask that you read them and if you have any questions, please feel free to ask any of our staff.

Office Policies - Cancellations are requested within *24 hours prior to scheduled appointment time* so we may accommodate those patients who are waiting. Broken appointments may be subject to a charge of $15. We reserve the right to bill this fee.

- We require your payment, including deductible amounts, co-payments, co-insurance amounts and non-covered service charges at the time of your visit. Do not hesitate to speak with us now if this presents a problem.
- Expenses for **ROUTINE FOOTCARE** are not a covered expense by Medicare and some other carriers. These expenses are payable at the time of service and additional to any other services provided by Dr. Reister.
- For your convenience, in addition to cash and check payments, we also accept Visa, MasterCard, American Express and Discover credit cards.
- There is a *$30.00 returned check fee* for any check returned by your bank. This fee covers our bank fee for the returned check.
- If at anytime you require copies of your medical records and/or x-rays, *your request must be made within 5 business days prior to the date of pickup.* We must have a signature release on file to release any medical records and/or x-rays.

Insurance –

- It is **YOUR RESPONSIBILITY TO VERIFY PARTICIPATION** of your healthcare providers with your insurance carrier. It is also advised that **YOU KNOW THE TERMS, LIMITATIONS AND BENEFITS OF THE PLAN YOU HAVE CHOSEN.**
- Although we verify benefits, **YOUR INSURANCE COMPANY HAS INFORMED US THAT VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT**. Payment of claims are subject to review and payment is determined upon receipt of the actual claim. You are responsible for services provided by our office. As a participating provider, we will accept payment for insurance portions from your carrier. Patient portions remain your responsibility at the time services are rendered.
- If a referral is required, it is **your responsibility to obtain these referrals**. If the proper referrals are not obtained **PRIOR** to your scheduled visit, full payment is due at the time of service.
- **"ROUTINE FOOTCARE"** is **NOT A COVERED EXPENSE** by Medicare or other insurance companies. Payment is expected in full at the time of service.

AUTHORIZATION TO RELEASE INFORMATION AND CONSENT FOR TREATMENT

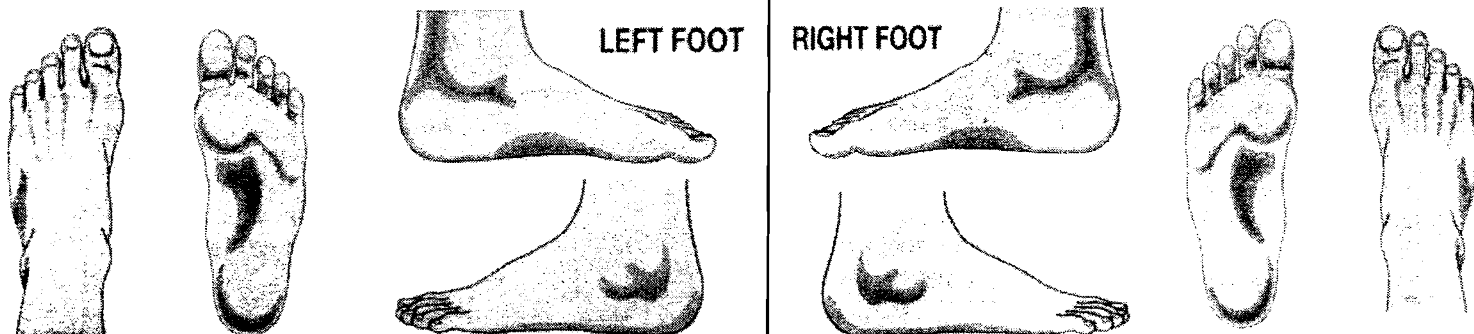
I consent to care and treatment by above physicians as may be prescribed by same and/or dictated by professional standards of practice for my illness or condition. The nature, purpose, benefits, and risks of all care and service have been explained to me. I authorize the release of any medical information to an individual agency, facility or medical personnel that would need this information to provide care to me. I consent to allow Dr. Reister and/or his staff to collect money due by my insurance carrier on my behalf. I also assign my Erisa rights, if applicable, to Dr. Reister and/or his staff should it be necessary to take legal action for non payment of my claims by the Erisa carrier. If I am a person different from the patient, this authorization is on the patient's behalf. I permit a copy of this authorization to be used in place of the original. **FINANCIAL POLICIES:** I understand I am responsible for any co-pay, co-insurance or non-covered services, and I authorize all insurance payments to be made directly to Dr. Gene G. Reister, D.P.M

SIGNATURE **DATE**

Patient Name______________________ ______________________ ______________________

PATIENT'S CHIEF COMPLAINTS

Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the areas where you have each problem using numbers 1& 2 to identify them.



Please mark the location of your first problem or pain on the diagrams above with a number 1. Describe your problem below. _____**Left Foot** _____**Right Foot** **My first problem:** ______________________ ______________________ ______________________ ______________________ **It causes me difficulty:(walking, wearing shoes, etc..)** ______________________ ______________________ ______________________ **Is this problem work related?**______________________ **Date of injury:**____/____/____	Pain/Discomfort is ☐ **Shooting Pain** ☐ **Throbbing Pain** ☐ **Sharp Pain** ☐ **Burning Pain** ☐ **Itching** ☐ **Aching Pain** ☐ **Tenderness** ☐ **Dull Pain** ☐ **Tingling** ☐ **Numbness**	**How long ago did the problem (pain) start?** _____days _____weeks_____ months_____ years **The pain from my problem occurs:** _____while walking **and/or** _____ while not walking **and/or** ______________________ ______________________ ______________________ ______________________ **Previous medical treatment(s) or home remedies:** ______________________ ______________________ ______________________ ______________________
Please mark the location of your second problem or pain on the diagrams above with a number 2. Describe your problem below. _____**Left Foot** _____**Right Foot** **My second problem:** ______________________ ______________________ ______________________ ______________________ ______________________ **It causes me difficulty:(walking, wearing shoes, etc..)** ______________________ ______________________ ______________________ **Is this problem work related?**______________________ **Date of injury:**____/____/____	**Pain/Discomfort is** ☐ **Shooting Pain** ☐ **Throbbing Pain** ☐ **Sharp Pain** ☐ **Burning Pain** ☐ **Itching** ☐ **Aching Pain** ☐ **Tenderness** ☐ **Dull Pain** ☐ **Tingling** ☐ **Numbness**	**How long ago did the problem (pain) start?** ____days ____weeks ____months ____years **The pain from my problem occurs:** ____while walking **and/or** ____while not walking **and/or**______________________ ______________________ ______________________ ______________________ **Previous medical treatment(s) or home remedies:** ______________________ ______________________ ______________________ ______________________

Do you currently wear Orthotics/Shoe Inserts now?___________ **Did you previously?**___________ **Do they or did they help?**___________

Do you have pain on your first steps out of bed or after being off your feet a while?_____________ Then subsides?_____________

Do you get leg cramps... during the day?________ **.... at night?**_________ **Percent of waking hours spent on your feet?**___________

Does foot pain limit your desired activities?___________ Any pain in calves or buttocks when walking?_________________

Is the pain relieved by stopping and standing still?_________________ **Do you have difficulty in walking?**_________________

List the sports/activities you are active in: ____

____

____

Gene G. Reister, D.P.M.
2001 North Collins #103
Richardson, TX 75080

Patie
Name:______________________________
D.O.B:______________________________

PATIENT MEDICAL HISTORY

Have you had/been treated for:

- ☐ Corns/Callouses
- ☐ Leg or Foot Ulcers
- ☐ Broken foot bone(s)
- ☐ Hammer/Mallet toes
- ☐ Cramps in legs/feet
- ☐ Lower back pain
- ☐ Gait(Walking) problems
- ☐ Childhood foot problems
- ☐ Warts
- ☐ Fungal Nails
- ☐ Neuroma
- ☐ Broken Ankles
- ☐ Bunions
- ☐ Arch Pain
- ☐ Knee Pain
- ☐ In-Toeing
- ☐ Rash
- ☐ Athlete's Foot
- ☐ Ingrown nails
- ☐ Foot Numbness
- ☐ Ankle sprain
- ☐ Flat feet
- ☐ High arch feet
- ☐ Heel pain
- ☐ Toe walking
- ☐ None of these

Do you have or have you ever been treated for:

- ☐ Stroke
- ☐ Phlebitis
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Gout
- ☐ Sciatica
- ☐ Alzheimer's
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Asthma
- ☐ Cancer
- ☐ Heart Attack
- ☐ Vascular Disease
- ☐ Poor Circulation
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Rheumatic Fever
- ☐ Keloid/Thick Scar
- ☐ Nerve Disorder
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Stomach Ulcer
- ☐ High Blood Pressure
- ☐ A Heart Condition
- ☐ Headaches
- ☐ Anemia
- ☐ Osteoporosis
- ☐ Lyme's Disease
- ☐ Hearing/Ear Disorder
- ☐ Psychiatric Disorder
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ None of these

List relationship to you of family members who have had:

- ☐ **Diabetes**______________________
- ☐ **Arthritis**______________________
- ☐ **Stroke**______________________
- ☐ **Cancer**______________________
- ☐ **Foot Problems**______________________
- ☐ **Heart Attack**______________________
- ☐ **High Blood Pressure**

Are you allergic to any medication, if so, please list______________________

What medications are you currently taking______________________

____

____

Do you have any other serious illness?______________________

____

Have you ever had surgery? If yes, please explain(include any complications):__________

____

____

Do you have vascular grafts?_________ Do you have joint implants?__________ **Do you have replacement heart valves?**__________

Are you now under chemotherapy?________ **Have you been tested for HIV(AIDS)?**____________ **Date:**__________ **Result: (Positive/Negative)**

Are you slow to heal after cuts?_________ **Any abnormal brusing?**_____________ Are you currently pregnant?____________

Do you drink alcoholic beverages? None Rarely Moderately Daily Quit Do you smoke cigarettes or tobacco?_______

Do you use recreational drugs? None Rarely Moderately Daily Quit

Is there any thing else that you want to tell the doctor?______________________

____

____

____

SIGNATURE ON FILE AND PERMISSION TO TREAT

I understand that the information provided on this form is true and correct to the best of my knowledge. I request that payments of authorized benefits be made on my behalf for any services furnished by Dr. Gene G. Reister, D.P.M. I authorize any holder of information about me to release any informaiton needed to determine these benifits or the benefits payable to related services to the insurance agent. I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required. I hereby give permission to Dr. Gene G. Reister, D.P.M. and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as my be deemed necessary.

Patient or Authorized Signature______________________________Date______________

If not patient, state relationship______________________________Date______________