

David Haddad DPM
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Richardson, TX 75080 (972) 690-5374



PATIENT DEMOGRAPHICS

First Name: _____ M.I.: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Patient DOB: ____/____/____ Driver's License: _____ State: _____ Social Security #: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____ Work Phone: (_____) _____

E-Mail Address: _____ Preferred name: _____

Do you have an Advanced Directive: ☐ Yes ☐ No (someone designated to act on your behalf, in the event of incapacity)

Emergency Contact: _____ Relationship to Patient: _____

Cell Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

Sex: ☐ F ☐ M Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed Race: _____

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No Preferred language: ☐ English ☐ Other: _____

Pharmacy: _____ Phone #: _____

Pharmacy Address: _____

Primary Care Physician: _____

Employed ☐ PT ☐ FT ☐ Retired ☐ Employer Name: _____

How did you hear about our practice? ☐ Internet (Source: _____) ☐ Friend/Family Member: _____

INSURANCE INFORMATION

Insurance ID & DL/Passport Front/Back of Card _____

PRIMARY

Insurance Company: _____ Insurance ID Number: _____

Group Number: _____ Primary Subscriber Name: _____

Primary Subscriber Birth Date: _____ Relationship to Patient: _____

SECONDARY

Insurance Company: _____ Insurance ID Number: _____

Group Number: _____ Secondary Subscriber Name: _____

Secondary Subscriber Birth Date: _____ Relationship to Patient: _____

Financially Responsible Person if not Patient: First Name: _____ Last Name: _____

Patient Name: _____ Date of Birth: ____/____/____ Today's Date: _____

NOTICE OF PATIENT FINANCIAL POLICY

It is our goal to partner with you in your care and financial obligations to our office. We will make every attempt to assist you to ensure that we not only provide excellent customer service, but to ensure that your plan processes your claims according to your policy guidelines. If you have any additional questions, please contact the Practice Manager. I acknowledge that I have read and understand the Patient Financial Policy

Signature Patient/Responsible Party: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices (NPP) contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information according to the Health Information Portability and Accountability Act (HIPAA). I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice. This authorization may be revoked by me at any time in writing. If I have a question, concern or complaint regarding our privacy practices, I understand that I can contact the office at (972) 690-5374 and speak to the Practice Manager.

I consent _____ or do not consent _____ and authorize Richardson Podiatry to use clinical photographs and videos for educational or promotional purposes.

I authorize the following people access to my personal health information upon request (including leaving a detailed message):

Name: _____ Relationship: _____ Phone: _____

Signature of Patient or Legal Representative: _____ Date: _____

CONSENT FOR ELECTRONIC COMMUNICATIONS

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in the addendum. I understand and accept the risks outlined in this consent form, associated with the use of the services in communications with the Physician and the Physician's staff.

You and the Physician will not use the services to communicate sensitive medical information about matters specified below [check all that apply]:

- ☐ Sexually transmitted disease
- ☐ AIDS/HIV
- ☐ Mental health
- ☐ Developmental disability
- ☐ Substance abuse
- ☐ Other(specify): _____

I acknowledge that the Physician or I may, at any time, withdraw the option of communicating electronically through the services upon providing written notice. Any questions I had have been answered.

Patient Signature: _____ Date: _____

SIGNATURE ON FILE AND PERMISSION TO TREAT

The above information is true to the best of my knowledge. I consent to care and treatment that may be prescribed by David Haddad DPM, Richardson Podiatry and its staff under standard of care and best practices. I certify that I have disclosed the most accurate insurance information available at the time of service and assign benefits directly to Richardson Podiatry, that may be otherwise payable to me for service(s) rendered. I understand that insurance is filed as a courtesy, and it is my responsibility to be fully informed of my plan benefits and that I am financially responsible for all charges whether paid by my insurance or denied due to policy guidelines or provisions. I authorize the use of my signature below on all insurance submissions. I further authorize Richardson Podiatry and its staff to use my health care information and may disclose medical records to my insurance company and their agents for the purpose of obtaining payment for services, determining eligibility or benefits, and appealing denied services until fully adjudicated.

Patient's Name (Print): _____

Signature Patient/ Responsible Party: _____ Date: _____

Relationship (if not Patient): _____

MEDICATIONS (include RX meds, OTC meds, and vitamins) Continue on back of page, if needed.

Medication	Dosage	Medications	Dosage	Other

PAST MEDICAL HISTORY

Are you Diabetic? ☐ Yes ☐ No If yes, name of physician of managing diabetes: _____
Diabetes: ☐ Type 1 ☐ Type 2 Duration: _____ years Date physician last seen: _____
Last blood sugar: _____ HbA1c: _____

Have you been treated for or have a history of any of the conditions below:

- ☐ **None of these**
 ☐ Warts
 ☐ Foot/leg ulcer
 ☐ Liver disease (Hepatitis)
 ☐ Pulmonary embolism
☐ Corns/callouses
☐ Neuroma
☐ Lower back pain
☐ Heart disease/Heart attack
☐ Thyroid condition (☐ Hi ☐ Lo)
☐ Blood Clot/DVT
☐ Arch pain
☐ Lung condition
☐ Broken bones in foot
☐ Seizure disorder/Epilepsy
☐ High Cholesterol
☐ Gout
☐ Poor circulation
☐ Hammer/Mallet Toes
☐ Cancer Type _____
☐ Fungal Nails
☐ Psychiatric disorder/Depression
☐ Osteomyelitis/Bone infection
☐ Cramps in Leg/Feet
☐ Bunions
☐ Leg cramps/Leg pain at rest
☐ Neuropathy Type: _____
☐ Charcot
☐ Stroke
☐ Sickle Cell Disease/Trait
☐ Gait/Ambulatory issues
☐ Ankle fracture or sprain
☐ Cellulitis/Skin infection
☐ Arthritis (Osteo / Rheum)
☐ High/Low Blood Pressure
☐ Excessive/Easy Bleeding
☐ Kidney disease (Dialysis)

ALLERGIES

- ☐ None ☐ Adhesives/Tape ☐ Aspirin ☐ Cortisone ☐ Sulfa Drugs ☐ Latex
☐ Codeine ☐ Local Anesthesia ☐ Penicillin ☐ Iodine ☐ Seafood/Shellfish ☐ Other: _____

PAST SURGERIES

- ☐ Foot/Ankle Surgery: _____
☐ Joint Replacement: _____
☐ Open Heart/Bypass Surgery
☐ Hysterectomy: ☐ Tubal ligation
☐ C-Section
☐ Stent Placement: ☐ Heart ☐ Leg
☐ Cosmetic Surgery: _____
☐ Appendix ☐ Gallbladder ☐ Tonsils/Adenoids
☐ Leg Bypass ☐ Open Fracture Repair
☐ Carotid Surgery ☐ Vein Surgery
☐ Hernia repair ☐ Thyroid ☐ Back surgery
☐ Other: _____ ☐ None

FAMILY HISTORY

- Mother • Father • Sister • Brother • Grandparent
Cancer ☐ M ☐ F ☐ S ☐ B ☐ GP
Diabetes ☐ M ☐ F ☐ S ☐ B ☐ GP
Gout ☐ M ☐ F ☐ S ☐ B ☐ GP
Heart Disease ☐ M ☐ F ☐ S ☐ B ☐ GP
High Blood Pressure ☐ M ☐ F ☐ S ☐ B ☐ GP
Chronic Arthritis ☐ M ☐ F ☐ S ☐ B ☐ GP
Anesthesia Complications ☐ M ☐ F ☐ S ☐ B ☐ GP
Foot Problems ☐ M ☐ F ☐ S ☐ B ☐ GP
Other: _____ ☐ M ☐ F ☐ S ☐ B ☐ GP
Other: _____ ☐ M ☐ F ☐ S ☐ B ☐ GP

Do you have Vascular Grafts? _____ Do you have joint implants? _____ Slow healing? _____

Do you have replacement Heart Valves? _____ Do you have a pacemaker? _____

Are you undergoing chemotherapy? _____ Have you been tested for HIV/AIDS? _____ Date: _____ Result: _____

Are you currently pregnant? _____ Abnormal bleeding issues? _____ Malignant hyperthermia? _____

SOCIAL HISTORY

I Stand _____ % of My Day I Live With: ☐ No One ☐ Spouse ☐ Children ☐ Parents ☐ Other: _____

I Drink Alcoholic Beverages: ☐ Yes ☐ No How much/often? _____

I Exercise Each Week: ☐ 0 days ☐ 1-2 days ☐ 3+ days

I Use or Have Used Tobacco Products: ☐ Yes ☐ No

Type: _____ Packs/Day _____ Years _____ When did you stop? _____

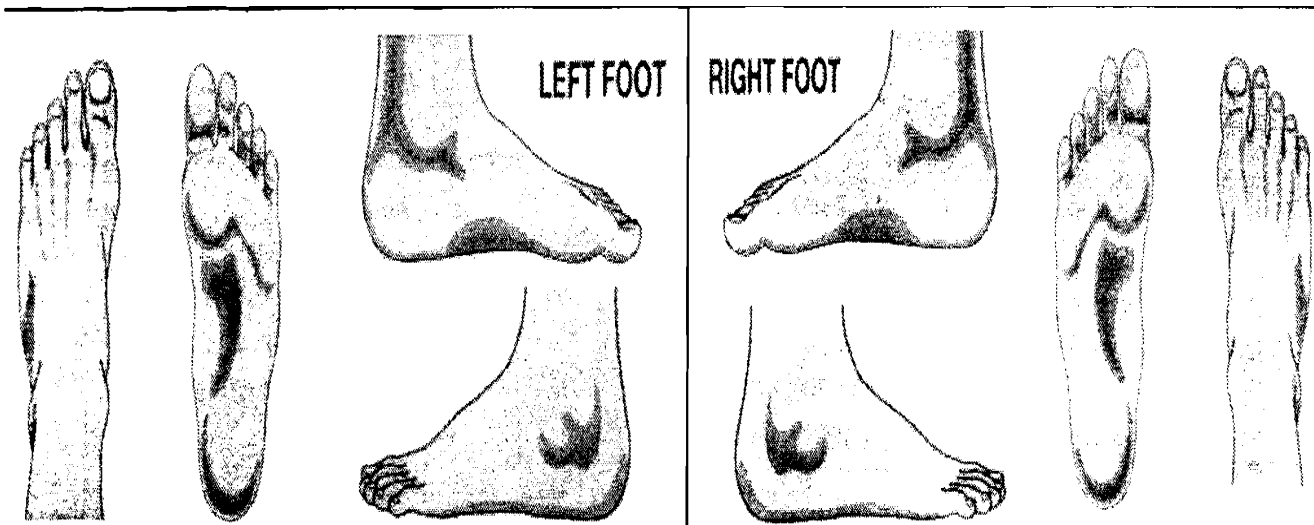
I Use or Have Used Illegal Drugs: ☐ Yes ☐ No _____

List Sports/Activities: _____

STATISTICS

Age: _____ Height: _____ Weight: _____ Shoe Size: _____

CURRENT SYMPTOMS: Please mark areas of discomfort on the diagrams below that are related to your visit.



When did the pain or symptoms begin: _____

Describe the problem: _____

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

How was the problem onset? ☐ Sudden ☐ Gradual

Accident Related: ☐ Yes ☐ No Work Related: ☐ Yes ☐ No Sports Related: ☐ Yes ☐ No

Is the pain relieved by stopping or standing still? ☐ Yes ☐ No Do you have difficulty walking? ☐ Yes ☐ No

The pain is worse when: _____

Rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain:

☐ Sharp ☐ Burning ☐ Clicking ☐ Aching ☐ Throbbing ☐ Tingling ☐ Shooting

☐ Dull ☐ Cramping ☐ Itching ☐ Popping ☐ Stabbing ☐ Other: _____

Previous medical treatment or home remedies: _____

Do any modalities or treatments help with the discomfort? _____

Do you currently wear Orthotics or shoe inserts? ☐ Yes ☐ No Have you previously worn them? ☐ Yes ☐ No

Did the Orthotics help? ☐ Yes ☐ No Percent of hours spent on your feet? _____

Do you get leg cramps? ☐ Yes ☐ No At night? ☐ Yes ☐ No

Does foot pain limit your desired activities? ☐ Yes ☐ No Do you have pain in calves or buttocks when walking? ☐ Yes ☐ No

Have you had a similar problem in the past? ☐ Yes ☐ No First visit to a doctor for this problem? ☐ Yes ☐ No