**COVID-19 SCREENING FORM**

**PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**TODAY’S DATE: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

Please circle YES or NO to the following questions:

1. Have you traveled outside of the USA in the last 14 days?

YES NO

1. Have you travelled within the USA in the last 14 days?

YES NO

1. Have you been on a cruise ship in the last 14 days?

YES NO

1. Have you and/or the patient been in close contact with anyone who has travelled domestically or internationally in the last 14 days?

YES NO

1. Have you been in close contact with a person known to have the 2019 Novel Coronavirus?

YES NO

1. Have you attended any events or gatherings with more than 100 people?

YES NO

1. Have you and/or the patient been asked to self-quarantine?

YES NO

1. Do you currently have a fever or lower respiratory symptoms such as a cough or shortness of breath?

YES NO

1. Do you have a new onset of cold symptoms such as cough and running nose?

YES NO

1. Have you received the covid vaccine? If YES, state the dates received: YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

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**Patient Name (FIRST AND LAST):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex:** \_\_\_M\_\_\_\_F **Social Security #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

**Marital status:** Married Divorced Single Widowed

**Employed**: \_\_\_Y\_\_\_N

**Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Work#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name (FIRST AND LAST):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Physicians Name (FIRST AND LAST):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Physician Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Last Seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Primary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Relationship to Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Shoe Size:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for your visit**: Please circle and be more specific:

**Which side:** LEFT RIGHT BOTH

**Where:** FOOT ANKLE TOENAIL TOE HEEL

**Other Details:**

**Pain Level (0-10):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Intake**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Caffeine Intake**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoker**: \_\_ \_\_\_ pack(s)/day **Previous smoker**: YES NO; How much/long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height**: \_\_\_\_\_ \_\_\_\_\_\_ **Weight**: \_\_\_\_\_\_ \_\_\_\_\_\_\_

**Constitutional:** Are you currently experiencing (please circle): Nausea Vomiting Fever Chills Night Sweats

**Have you had a Flu shot this season?** YES | NO

**Have you had the pneumonia vaccine?** YES | NO

**Medications**: List of current medications & dosage:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Medical History:** If you now have or have ever had any of the following conditions, please circle and be more specific in the blank space below:

Thyroid Problems Hepatitis\_\_\_\_\_\_\_\_\_\_\_

Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_ Ear Disorders\_\_\_\_\_\_\_\_ Multiple Sclerosis Hearing Loss

Circulation Problems Eye Disorders \_\_\_\_\_\_\_\_

Heart Disease\_\_\_\_\_\_ ADD/ADHD

Alcohol Dependency

Heart Burn/Reflux Lymphedema

Anxiety

Bipolar Disorder

Back Problems

Anemia \_\_\_\_\_\_\_\_\_\_\_ Currently Pregnant Depression

High Blood Pressure Children/Pregnancies Fibromyalgia

Asthma

High Cholesterol

Gout

Prostate Problems Breathing Problems Current Kidney Dialysis Osteoarthritis

Lupus

Pre-Diabetes

Diabetes: Type I or II

# of years \_\_\_\_\_\_

HIV/AIDS

Osteoporosis

Low Bone density Kidney Problems

Neuropathy

Parkinson’s Alzheimer’s/ Dementia

Drug Dependency

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies:** YES OR NO; If yes, please list: **Reactions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History:** Please circle any medical conditions that run in your family and write which member(s) affected.

Diabetes\_\_\_\_\_\_\_\_\_\_ Gout\_\_\_\_\_\_\_\_\_ heart disease\_\_\_\_\_\_\_\_\_\_ Circulation Problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure\_\_\_\_\_\_\_\_\_\_ High Cholesterol\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** List all surgeries you have had. Begin with the most recent. Please state the year. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy phone#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **diabetic**, who manages your diabetes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last A1C? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Performed by/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAD Patient Intake Decision Tree (SMART LEDA Questionnaire)**

Answering the following questions will help determine if you are at risk for Peripheral Arterial Disease (PAD) and if vascular examination can help better assess your vascular health status.

Patient’s Name: Date:

1. Do you experience any pain in your legs or feet while resting?

YES NO

1. Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip, or thigh during walking/exercise?

YES NO

1. If yes to question 2, does the pain go away when you stop walking/exercising?

YES NO

1. Do your feet get pale, discolored, or bluish at any time during the day?

YES NO

1. Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?

YES NO

1. Are you over the age of 50?

YES NO

1. Do you have High cholesterol or other blood lipid (fat) problems or require cholesterol medication?

YES NO

1. Do you have high blood pressure or take medication to reduce blood pressure?

YES NO

1. Do you have Diabetes?

YES NO

1. Do you have a history of chronic kidney disease?

YES NO

1. Do you currently or have ever smoked?

YES NO

1. Do you have any history of a stroke or mini stroke (TIA)?

YES NO

1. Do you have a history of heart disease (heart attack, MI)?

YES NO

1. Do you have a history of carotids stenosis, AA (abdominal aortic aneurysm), and/or stent placement?

YES NO

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**PRIVACY POLICY**

I hereby authorize Texas Foot and Ankle Consultants LLC to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Texas Foot and Ankle Consultants LLC on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Texas Foot and Ankle Consultants LLC for charges for the above patient regardless of my insurance coverage. I also understand that Texas Foot and Ankle Consultants LLC is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Texas Foot and Ankle Consultants LLC permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained during my treatment. **I allow Texas Foot and Ankle Consultants LLC** **to receive and release my personal and medical information that may be pertaining to my treatment, medical history, and diagnosis.**

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FINANCIAL POLICY**

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.
* Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash, or check.
* 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 doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, you will receive a bill.
* 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 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’s changes and authorization/ referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
* There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery or at the time of your Pre-op appointment.
* 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 to the office.
* Patients who are 90 days past due on their balance will be sent to collections unless a payment plan has been put into place.
* There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
* In fairness to all our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours’ notice will result in a fee of $25.00. You might be asked to pay before you are seen by the doctor.
* Patients who come to the office fifteen minutes later than scheduled appointment might be asked to reschedule.

Signature of Patient/ Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient/ Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

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**WORK FORM POLICY**

Work forms to be filled out by the physician, please allow 7 to 14 business days to complete these forms.

The only documentation regarding your health or illness required by law (and included in the office visit charge) is an office visit note.

Completing paperwork for schools, camps, the Family Medical Leave Act (FMLA) Claims, Long-term care, Life Insurance, the Department of Veterans’ Affairs, Disability Claims, or other purposes is unnecessary duplication and goes beyond routine medical care. Therefore, it cannot be billed to your insurance company. Since all forms require our signature, we are personally responsible for the accuracy of the information provided. Incomplete or inaccurate information may have far-reaching consequences for your case. Filling out forms requires careful consideration and a considerable amount of time.

Therefore, it is our office policy to charge for the completion of a form as follows:

Processing fee of $25.00 per form

Patient signature: Date: