Kent H. Olsen, DPM
Irving Foot and Ankle
2001 N. MacArthur Blvd.
Suite 300
Irving, TX 75061
O:972-254-0680 f: 972-254-0683

WELCOME TO IRVING FOOT & ANKLE CENTER

PATIENT INFORMATION

(This confidential information is importan so we can learn about your health)

Name: _____Date:_____
Last First M.I.

Date of Birth (DOB): _____ Age: _____ Sex:_____

Race: _____ Ethnicity: _____ Primary language: _____

Drivers License #: _____ Social Security #_____

Home Phone: _____ Mobile #: _____

Email: _____

Home Address: _____
STREET CITY STATE ZIP

INSURANCE INFORMATION

Primary Medical Insurance: _____

ID/Member#:_____ Group/Policy #: _____

Secondary Insurance_____

ID/Member # _____ Group/Policy #: _____

RESPNSIBLE PARTY: (SELF/NAME OF PERSON INSURANCE IS CARRIED BY OR PRIMARY CARRIER OF THE INSURANCE)

Name of Insuranced (if other than patient): _____

Date Of Birth: _____ Age: _____Social Security#:_____

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Employed by: _____Work Phone: _____
Address if different from patient: _____

EMPLOYMENT: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Student
Employed By: _____Work Phone: _____Ext:_____
Work Address: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse (Parent) Name: _____Spouse (Parent) DOB: _____

Spouse (Parent) Occupation: _____Spouse (Parent) Phone# _____

REFERRRED BY: ☐ Doctor: _____ ☐ Patient/Friend: _____

☐ Insurance ☐ Online Search ☐ Social Media (Facebook. Google, ext.)

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____Home Phone: _____

Address: _____
STREET CITY STATE ZIP
Cell #: _____ Work #: _____ Ext: _____

PREFERRED PHARMACY INFORMATION:

Pharmacy Name: _____Phone Number: _____

Pharmacy Address: _____
STREET CITY STATE ZIP

I herby give my permission to Dr. Kent Olsen, DPM; his associates or assistants to examine and administer treatment as may be deemed necessary during the care of my condition. I understand that I am financially responsible for all charges, whether or not paid by insurance. The only limatation to my financial liability for charges not paid by insurance occurs in the event of contractual limitations to the charged fees that have been agreed upon by Irving Foot & Ankle (Comfort Podiatry) and the insurance Company.

_____ _____

Signature Date

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MEDICAL IFORMATION

What is your foot/ankle problem?_____

_____

Duration? _____Days:_____Weeks:_____Months:_____Years:_____ R or L Foot?_____

Any Prior Treatment? _____By Whom?_____

Primary Physician: _____ Date of Last Exam: _____

Former Podiatrist: _____

Have you had any problems whit your feet or ankles? _____

Have you had any operations (surgery) whit your feet or ankles? _____

GENERAL HEALTH INFORMATION:

Weight: _____ Height: _____ Current Shoe Size/Width _____ Type of shoe normally worn: _____

Do you have Diabetes? ☐ Yes ☐ No. If yes, do you take Insulin? ☐ Yes: ☐ No of Years _____

Have you had any serious illness or have you had any surgery? ☐ Yes ☐ No If yes, what: _____

_____

Are you currently under the care of any other physician? ☐ Yes ☐ No If yes for what problem(s)? _____

_____

Do you or did you smoke, dip or chew tobacco? ☐ Yes ☐ No If yes, number of packs/ cigars per day: _____ number of years: _____ if you quit using tobacco, how long ago? _____

Do you drink beer, wine or alcohol? ☐ Yes ☐ No If yes, ☐ occasional ☐ moderate ☐ heavy

Do you drink beverages with caffeine? ☐ Yes ☐ No If yes, ☐ coffee ☐ tea ☐ soft drinks

At your job do you ☐ sit most of the time ☐ stand most of the time ☐ stand and walk

Does your employer require you to wear certain shoes at work? ☐ Yes ☐ No If yes, are the shoes

☐ Boots with steel toes ☐ dress [men] fashion shoes [women] high heels

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Please list all medications you take

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____
16 _____
17 _____
18 _____
19 _____
20 _____

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Please check if you have ALLERGIES (REACTIONS) to:

- ☐ Penicillin
- ☐ Sulfa
- ☐ Iodine (Betadine or dye)
- ☐ Keflex
- ☐ Tetaccycline
- ☐ Davon/Darvocet
- ☐ Erythromycin
- ☐ Aspirin
- ☐ Anti-inflammatory (Naprosyn, Advil, Motrin, Aleve, et)
- ☐ Codeine
- ☐ Morphine or Demerol
- ☐ Local anesthesia
- ☐ Adhesive tape: Band-aids
- ☐ Other(s)

_____

_____

_____

Do you have any artificial joint(s) or heart valve: ☐ Yes ☐ No If yes, where: _____

Please check if you have a problem with any of the following:

- ☐ Frequent fainting
- ☐ Dizziness
- ☐ Migraine(s)
- ☐ Weight loss
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Teeth or gum problems
- ☐ Blood transfusion(s)
- ☐ Heart attack
- ☐ Mitral valve problems
- ☐ Obstructive pulmonary disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ AIDS/ HIV/ ARC
- ☐ Getting up to urinate after going to bed
- ☐ Urinary incontinence
- ☐ Hemorrhoids
- ☐ Prostate problems
- ☐ Yeast infections
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Stiffness
- ☐ Chronic low back pain
- ☐ Thick scar or keloid formation
- ☐ Skin rash or keloid
- ☐ Skin Cancer
- ☐ Tattoo(s)
- ☐ Tingling in arms, hands, legs or feet
- ☐ Memory loss
- ☐ Depression
- ☐ Panic attacks
- ☐ Obsessive-compulsive disorder
- ☐ Menopause
- ☐ Sickle cell disease or trait
- ☐ Anemia
- ☐ Gout
- ☐ Frequent infections
- ☐ Asthma
- ☐ Other Cancer(s)

_____

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☐ Rheumatic Fever ☐ Numbness or burning in arms, hands, or feet

☐ Gastric reflux

FAMILY HISTORY:

Mother ☐ Living ☐ Deceased Cause of death: _____

Father ☐ Living ☐ Deceased Cause of death: _____

Brother ☐ Living ☐ Deceased Cause of death: _____

Sister ☐ Living ☐ Deceased Cause of death: _____

Please check if there is a family member (blood relative) history of:

☐ Arthritis ☐ Sickle Cell ☐ Flat Feet ☐ Neurologic disorders

☐ Heart Disease ☐ Diabetes ☐ Bunions

☐ Bleeding disorders ☐ Gout ☐ Hammertoes

_____ _____

Signature Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) Date

_____

Patient Name or Name of Authorized Representative (if applicable)

_____

Signature

☐ I hereby give my permission to Dr. Kent Olsen DPM to disclose and discuss any information related to my medical condition(s) to/with the following family member(s) other relatives and/or close personal friends.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

☐ I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition.

_____ _____

Signature Date

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LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL RECORDS AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred.

I, _____ the undersigned have insurance and/or employee health care benefits coverage with the enclosed caption, and hereby assign and convey directly to Dr. Kent Olsen DPM all medical benefits and/or insurance reimbursement, if any, otherwise payable to me or services rendered from the above named podiatrist. I understand thati am financially responsible for all charges regardless of any applicable insurance or benefit payment and understand that these balances are due within ninety (90) days from the date of insurance payment and/or denial and if outside attempts are necessary. I will also be responsible for all collection and legal fees. I hereby authorize Dr. Kent Olsen DPM to release all medical information to process my claims. I hereby authorize any plan administrator or fiduciary, insurer and mt attorney to release to Dr. Kent Olsen DPM any and all plan documents, insurance policy and/or settlement information upon written request from Dr. Kent Olsen DPM. In order to claim such medical benefits, reimbursement or any applicable remedies. I authorize use of this signature on all my insurance and/or employee health benefit claim submissions.

I hereby convey to Dr. Kent Olsen DPM to the full extent possible under the law and under any applicable insurance polices and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or health care plan with respect to medical expenses incurred as a result of the medical services I received from Dr. Kent Olsen DPM and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further in response to any reasonable request for cooperation, I agree to cooperate with Dr. Kent Olsen DPM in any attempts by Dr. Kent Olsen DPM to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bringing in suit with Dr. Kent Olsen DPM against such insurers and/or employee health care plan in my name, but at Dr. Kent Olsen DPM expense.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and understood this assignment.

_____ _____

Signature of insured/ Guardian Date

Relationship of Guardian to minor child_____

_____

Witness

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PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, Irving Foot & Ankle now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you with to have the opportunity to receive information of this type, please complete the form below.

Irving Foot & Ankle believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from Irving Foot & Ankle via e-mail or text messaging.

Irving Foot & Ankle does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company or with any other patient.

Please print all information neatly and legibly.

_____

Name

_____

E-mail Address

_____

Cell Phone Number

☐ Yes, please sign me up to receive both email and text messages confirmations.

☐ Yes, please sign me up to receive text messages ONLY. I DO NOT wish to be contacted via email.

☐ Yes, please sign me up to receive email ONLY. I DO NOT wish to be contacted via text messaging.

☐ I DO NOT wish to be contacted by either text messaging or via email.