

Hub City Foot & Ankle PLLC- New Patient Information Form

PATIENT INFORMATION

Patient First and Last Name: _____

Date of Birth: ____/____/____ Age: _____ Sex: Male Female Other _____

Social Security Number: _____ Marital Status: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Parent/Guardian Name (if minor): _____

Primary Phone: _____ Secondary Phone: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____ Phone Number: _____

PRIMARY CARE PROVIDER

PCP: _____ Phone Number: _____

Referring Provider: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Location: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Member ID: _____

Group Number: _____ Policy Holder Name: _____

Relationship: Self Spouse Parent Other Policy Holder DOB: _____

I hereby give permission to Dr. Harper or whomever he may designate to administer treatment and to perform procedures as may be deemed necessary in the diagnosis and treatment of my foot or ankle condition.

Signature: _____ Date: _____

Hub City Foot and Ankle PLLC

Sean Harper, DPM 4002 22nd Street, Lubbock, TX 79410 Phone: 806-407-5129 Fax: 806-407-5223

Insurance Assignment, Financial Responsibility, and Privacy Practices

Insurance Assignment

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and/or supplemental insurance, to Hub City Foot and Ankle PLLC. This assignment shall remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether insurance pays or not. I authorize Hub City Foot and Ankle PLLC to release any information necessary to secure payment of benefits.

Patient/Guardian Signature: _____ Date: _____

Medicare Beneficiary Acknowledgement

If applicable, I understand that some services may not be covered by Medicare and I may be financially responsible for those services.

Patient/Guardian Signature: _____ Date: _____

Financial Policy

I understand that co-pays, deductibles, coinsurance, and non-covered services are my responsibility.

Patient/Guardian Signature: _____ Date: _____

Acknowledgment of HIPAA Notice of Privacy Practices (NPP)

I acknowledge that I have received or been offered a copy of Hub City Foot and Ankle PLLC's NPP.

Patient/Guardian Signature: _____ Date: _____

Authorization to Discuss Medical and Financial Information

I authorize Hub City Foot and Ankle PLLC to discuss my appointment, medical, and/or financial information with the individuals listed below. This authorization shall remain in effect until revoked by me in writing.

Name	Relationship	Phone Number

I do not authorize Hub City Foot and Ankle to discuss my medical/financial information with any other person.

Patient/Guardian Signature: _____ Date: _____

Communication Preferences

I authorize Hub City Foot & Ankle PLLC to contact me regarding appointments, treatment, billing, and other healthcare-related matters by:

Phone Voicemail Text Message Email

Patient/Guardian Signature: _____ Date: _____

Hub City Foot and Ankle PLLC

New Patient Paperwork

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

What is your - Height: _____ Weight: _____ Age: _____

List **ANY ALLERGIES** and significant side effects (i.e., hives, anaphylaxis)?

What pharmacy do you use? _____

What brings you here today? (Describe which foot/ankle, and the problem you are having)

How long have you had this problem? _____

____ Days _____ Weeks _____ Months _____ Years

When do you experience the problem? _____

____ Constant _____ Frequently _____ Occasionally _____ Rarely _____ Nighttime

Are you a Diabetic? ___Y ___N **Treating Doctor/Endocrinologist:** _____

Most Recent A1C: _____ **Are you on insulin:** ___Y ___N **Blood thinner:** ___Y ___N

Do you have a heart condition? ___Y ___N **Who is your cardiologist:** _____

Medical History: Please circle **any/all** of the following **you currently or have ever had:**

- | | | | |
|---------------------|----------------|---------------------|---------------------|
| High blood pressure | Heart Problems | Bleeding Problems | Blood Clots |
| HIV/Hepatitis | COPD | Lung Infection / TB | Asthma |
| Dialysis | Stroke | Diabetes I or II | Heart Attack |
| Psoriasis | Gout | Kidney Failure | Autoimmune Disorder |
| Thyroid Disorder | Arthritis/RA | Anesthesia Problems | Cancer |
| Ulcers | Sleep Apnea | Fibromyalgia | Back Surgery |

Please list **all** medications you are currently taking (prescription and over the counter):

I have a list to attach: _____

Name of Medication	Dosage (mg/mcg/unit)	How Often?

Continued On Back

Any Other Serious Medical/Psychiatric Problems or Recent Hospitalizations?

Family History (Mother, Father, Brother, Sister):

Arthritis Diabetes Heart Problems Anesthesia Problems
Bleeding Problems Blood Clots Foot Problems

Social History:

Do you drink alcohol? Yes No – How much/How often: _____

Do you smoke/vape/dip: Yes No – Daily Quantity? _____ How long? _____

Are you a FORMER tobacco user? Yes No Product/how long: _____

Illicit Drug use: _____ Yes _____ No

Please list any past surgeries and dates (i.e. bypass, stenting, bunion surgery, etc.):

Review of Systems - Please circle any/all of the following **you** have experienced:

General: Fever, Chills, Fatigue

Chest: Shortness of Breath, Chest Pain, Palpitations

GI: Nausea, Vomiting, Diarrhea, Constipation

Blood: Excessive Bleeding, Blood Clots, Excessive Thirst or Urination

Musculoskeletal: Back or Neck Pain, Muscle or Nerve Pain with Walking

Skin: Rash, Sores, Poor Healing

Nerves: Loss of Strength/Balance, Sciatica, Burning, Numbness, Tingling, Confusion

Signature: _____ Date: _____