

## Patient Information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birth Date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-Mail \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
Notify in case of emergency (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Primary Insurance Company \_\_\_\_\_ Guarantor \_\_\_\_\_ DOB: \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_ Guarantor \_\_\_\_\_ DOB: \_\_\_\_\_

## If Minor

If parents are not married, who has legal custody? \_\_\_ Father \_\_\_ Mother \_\_\_ Legal Guardian  
Legal Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_  
Legal Guardian's Address \_\_\_\_\_  
Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
**Father's Name** \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birth Date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
**Mother's Name** \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birth Date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Authorization

Initial \_\_\_\_\_

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. \_\_\_\_\_

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I have also read and understand the attached "FAMILY FOOT & ANKLE SPECIALISTS PATIENT FINANCIAL RESPONSIBILITY INFORMATION" and "NOTICE OF PRIVACY PRACTICES." \_\_\_\_\_

I authorize the doctor to release all information necessary to secure the payment of benefits. \_\_\_\_\_

I understand that I am financially responsible for all charges whether or not paid by insurance. \_\_\_\_\_

I hereby give my permission for the doctor to render a Podiatric examination and treatment. \_\_\_\_\_

## Patient Authorization to Discuss Medical Information

I understand that pursuant to Texas law, my medical condition is confidential. In order for my physician and staff to discuss my medical conditions with my family members (including spouse) or friends, I understand that I must give written authorization. Therefore, I \_\_\_\_\_ hereby give Dr. Steven P. Brancheau/Dr. David D. Minchey/Dr. Lesley Richey-Smith and Staff the authority to discuss my medical condition with the following individuals.

\*\*\*\*\*If you do not wish for anyone to be allowed this information, Please state none.\*\*\*\*\*

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Any change in the designation must be in writing and it can be changed at any time.

**I confirm that I have received, read and agree to all forms of terms, conditions and consent to treat.**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient/Insured)

High Standards of professional service requires the doctor to devote to each patient ample time to consider his individual problem. For this reason, delays may occur in our carefully planned appointment schedule.