Jeffrey R Cohen DPM FACFAS Brenda Cohen DPM Jon Smedley DPM FACFAS Ryan Shock DPM
7200 Wyoming Springs Suite 1150 Round Rock, Texas 78681 (512) 255-0125 Fax (512) 255-0153
1103 Cypress Creek Suite 101 Cedar Park, Texas 78613 (512) 336-2300 Fax (512) 336-2301
6611 River Place Blvd Suite 200 Austin, Texas 78730 (512) 351-9149 Fax (512) 351-9376

Name_____ Phone#: ( )_____
Last First MI Cell PH#: ( )_____
Mailing
Address_____City_____ST_____ZIP_____
S.S.#:_____ Sex M / F
Marital Status_____
Birthdate _____/_____/_____
Language_____
Race_____
Employer_____ Work PH#:( )_____
Email_____

Insurance Information

Primary Insurance_____
Policy Holder Name_____
Employer_____
SSN:_____Birthdate:____/____/____
Relation to Patient_____

Secondary Insurance_____
Policy Holder_____
Employer_____
SSN:_____Birthdate:____/_____/____
Relation to Patient_____

Emergency Contact

Name_____Relation to Patient_____
Ph#:( )_____

If accident, was it related to work___auto___ or other____? List date of injury_____
And a brief description of how it happened?

_____
_____
_____
_____

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Consent for Treatment

To the best of my knowledge, the information given is correct. I hereby give my permission to Precision Podiatry, its physicians to administer treatment and to perform such procedures as deemed necessary in the diagnosis and/or treatment of my foot condition.

Signature of Patient/Guardian_____Date_____

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES INFORMATION _____(INITIALS).

Consent to Bill Insurance

Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your contract with them and with our office. **It is your responsibility to pay the deductible, co-insurance, and any other balances not paid by your insurance.** We will assist you in receiving reimbursement as much as possible. But you are responsible for you bill. By signing this you understand and agree that (regardless of insurance status), you are ultimately responsible for the balance of your account for any professional services rendered. You certify that all the information given is true and correct to the best of your knowledge. You will notify us of any changes in your status or the above information.

No show policy as of August 1. 2001: Patients arriving 15 minutes past their appointment time may be rescheduled. Any appointment rescheduled within less then 25 hours notice or no show appointments are subject to a $25.00 fee.

Your signature is necessary for us to process any information claims and to ensure payment of services rendered.

The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Precision Podiatry and its physicians. I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of the clean claim. 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.

Patient Signature_____Date_____

The Medicare Patient

I request that payment of authorized Medicare Benefits be made to me, or on my behalf to Precision Podiatry and its physicians for any services furnished to me by the provider. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents needed to determine benefits, of the benefits payable for related services. 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.

Patient Signature_____Date_____

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I give Precision Podiatry permission to release the following information to the following person's on my behalf.

_____ Relation to patient_____

☐ Medical ☐ Billing

_____ Relation to patient_____

☐ Medical ☐ Billing

_____
(Print Name)

_____
(Signature)

☐ I do NOT give my permission to release any information to any person on my behalf

_____
(Print Name)

_____
(Signature)

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Patient:_____DOB___/___/___ Date:_____
Height:_____ Weight:_____ Shoe Size:_____
Reason for visit
_____
_____
_____
Drug Allergies:
_____
Medications:
_____
_____
Pharmacy Name and Location/phone number/zip code_____
_____
Circle One: Smoker Non-Smoker Former Smoker
Alcohol Use: Yes No Recreational Drug Use: Yes No

Medical History (please check all that apply)

- **Rheumatic Fever**
- **Polio**
- **Diabetes Mellitus**
- **High Blood Pressure**
- **Stroke**
- **Hepatitis**
- **Gout**
- **Asthma**
- **Cancer**
- **Liver Disease**
- **Kidney Disease**
- **Lung Disease**
- **Stomach Ulcer**
- **Heart Condition**
- **Headaches**
- **Anemia**
- **Osteoporosis**
- **Psychiatric Disorder**
- **Thyroid Problem**
- **Tuberculosis**
- **Other_____**

List Surgeries (include dates)
_____
_____
_____

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Family History (check all that apply)

- **Diabetes**
- **Arthritis**
- **Stroke**
- **Cancer**
- **Heart Attack**
- **High blood Pressure**
- **Birth Defects**
- **Anesthesia Reaction**
- **Bleeding Problems**
- **Other_____**

Are you currently suffering from any problems listed below? (Please circle all that apply)
Head: chronic headaches, concussions, dizziness, loss of consciousness
Eyes: Glasses, contacts, double cission, blurred vision, blindness, glaucoma, cataracts
Ears: Decrease or loss of hearing, tinnitus, chronic earaches, drainage or infections
Throat: chronic tonsillitis, laryngitis, dysphasia, loss of speech, thyroid disorder
Nose: choronic drainage, blockage, epistaxis, sinusitis
CVS: heart attack, high blood pressure, rheumatic fever, chest pain, shortness of breath, fluttering, heart murmur, valvular disease, anemia
Respiratory: asthma, difficulty night breathing, TB, pleurisy, emphysema, pneumonia
G.I: peptic or deudenal ulcer, chronic nausea, vomiting, diarrhea, constipation, weight gain or loss, jaundice, hepatitis, gall bladder disease, gallstones, blood in stool, hematemesis, colitis, diverticulitis, polyps, appetite disorders
G.U.: chronic kidney or bladder infections, stones, dysuria, pyuria, hematuria, venereal disease
GYN: dysmenorrheal, amenorrhea
Musk: gout, rheumatoid arthritis, osteoarthritis, trauma, fracture, dislocations

Please tell us whom we can thank for referring you.
Name_____

Please tell us whom to coordinate your care.
Primary Care Physicians name & ph.#_____