Denton Podiatry
Foot and Ankle Specialists
2535 Charlotte St, Suite 102, Denton, TX 76201
Ph: 940-566-1919

Patient Registration

Patient Full Name | Date of Birth (MM/DD/YYYY)

Address

City | State | Zip

Email | Phone

Emergency Contact | Relation | Phone

Responsible Party (if other than Patient)

Full Name | Date of Birth (MM/DD/YYYY)

Address

City | State | Zip

Home Phone | Cell Phone | Email

Patient / Responsible Party Employment

Employer | Occupation

Employer Address

City | State | Zip | Work Phone

Insurance Information

Insured (if different from Patient) | Date of Birth (MM/DD/YYYY)

Relationship to Patient (Please select): ☐ Self ☐ Spouse ☐ Child ☐ Other Dependent

Primary Health Insurance | Member ID | Group #

Secondary Health Insurance | Member ID | Group #

Co-Pay Amount

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Patient Medical Information

Patient Name _____ Date of Birth (MM/DD/YYYY) _____

Sex (Please select): ☐ Male ☐ Female

Primary Care Provider

Name / Clinic _____ Phone _____ Last Seen _____

Foot Concern

What foot problem(s) are you having? _____

Allergies to Medications _____

List all medications: _____

_____

Lifestyle

Do you smoke? (Please select): ☐ Yes ☐ No ☐ Former Smoker (_____ Year)

Alcohol consumption (Please select): ☐ None ☐ Occasional ☐ Frequently ☐ Daily

Are you pregnant? (Please select): ☐ Yes ☐ No

Family History (Please select)

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Heart Problem ☐ Arthritis ☐ Unknown

Surgery History (Please select)

☐ Heart Surgery ☐ Joint Replacement ☐ Vascular Surgery ☐ Back Surgery ☐ Foot Surgery ☐ None

Other Surgeries _____

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Medical History

Patient Name _____ Date of Birth (MM/DD/YYYY) _____

Personal Medical History (Please select all that apply)

- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Blood Clots / DVT
- ☐ Cancer
- ☐ Chest Pain
- ☐ Emphysema
- ☐ Epilepsy or Seizure
- ☐ Foot Ulcer
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Conditions
- ☐ Hepatitis / Liver Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Low Back Pain
- ☐ Lung Disease
- ☐ MRSA Infection
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Poor Circulation
- ☐ Psychiatric Care
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis

Diabetes

Do you have diabetes? (Please select): ☐ Yes ☐ No

If yes, please provide the following:

Type (Please select): ☐ Type 1 ☐ Type 2

Doctor (if different than Primary Care Provider) _____ Date Last Seen _____ Last A1C _____

Treatment (Please select): ☐ Insulin ☐ Orals ☐ Both ☐ Neither

Have you had foot surgery due to diabetes? (Please select): ☐ Yes ☐ No

Additional

Height _____ Weight _____ Shoe Size _____ Pharmacy Location _____

Other conditions or important information we should know about _____

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HIPAA Compliant Patient Consent Form

Print Patient Name _____ Birth Date (MM/DD/YYYY) _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. By your signature below, you acknowledge that you have reviewed our Notice of Privacy Practices. The terms of the notice may change, and if so, you will be notified on your next visit.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree to a requested restriction, but if we do, we shall honor it.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) allows for the use and disclosure of protected health information for treatment, payment, and healthcare operations. By signing this form, you consent to our use and disclosure of your protected health information as permitted by law. Audio recordings created for clinical documentation purposes, if any, are considered protected health information and are subject to the same privacy and security safeguards.

You have the right to revoke this consent in writing. Such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed for treatment, payment, or healthcare operations.
- Denton Podiatry, PLLC reserves the right to change privacy practices as permitted by law.
- I have the right to request restrictions on the use of my information, although the practice is not required to agree.
- I have the right to revoke this consent in writing at any time, except to the extent action has already been taken in reliance on it.
- The practice may condition receipt of treatment upon acknowledgment of receipt of the Notice of Privacy Practices.

Patient also agrees to:

- Allow phone calls, emails, and texts for communications.
- Allow voice messages to be left on answering machines and/or voicemail.
- Allow prior medical history and prescription records to be accessed and reviewed.

May we discuss your medical information with emergency contact? ☐ Yes ☐ No

If yes, name and relationship of emergency contact(s) _____

Relation _____ Phone _____

Signature of Patient / Responsible Party _____ Date _____

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Treatment Consent

Print Patient Name _____ Birth Date (MM/DD/YYYY) _____

I consent to evaluation and treatment of the condition for which I, my child/dependent, have come to Denton Podiatry, PLLC (the practice) for, and authorize the physicians and other health care providers affiliated with Denton Podiatry, PLLC to provide treatment. I acknowledge and agree that this consent will be applicable to all visits of evaluation and treatment.

I take responsibility for payment of the treatment to me/my child/dependent. I authorize Denton Podiatry, PLLC to bill and be paid directly by any insurer for all charges incurred in connection with the diagnosis, care, and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as any deductible, co-payment, co-insurance, or charges not covered by health insurance. I understand that certain payments may be required at the time services are rendered. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them.

If I elect to pay for medical treatment in cash, in full, before services are provided, I can request that my health insurance, in any form, not be billed for that service, nor notified that the service was provided.

I am responsible for notification to my insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying Denton Podiatry, PLLC for the services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.

If I default or do not pay for treatment provided, I acknowledge and agree that Denton Podiatry, PLLC is entitled to recover the full amount of the debt owed for medical services, collection expenses, and attorney fees charged to Denton Podiatry, PLLC to complete the collection.

_____ _____

Signature of Patient / Responsible Party Date

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Patient Rights, Responsibilities, and Conduct Policy

Print Patient Name _____ Birth Date (MM/DD/YYYY) _____

I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand. I agree to provide accurate and complete information about my health history and presenting complaints. It is my responsibility to agree upon a treatment plan and follow that plan. I understand that my health care providers will treat me with respect, and I agree to do the same for them.

I understand and agree that Denton Podiatry, PLLC is committed to maintaining a safe, respectful, and professional environment for patients, staff, and providers. Verbal abuse, threats, harassment, intimidation, aggressive or disruptive behavior, or conduct that interferes with safe and effective delivery of care will not be tolerated.

I acknowledge that Denton Podiatry, PLLC reserves the right to refuse or discontinue non-emergency services, dismiss a patient from the premises, or formally terminate the provider-patient relationship if patient behavior jeopardizes the safety or well-being of staff or other patients, or materially disrupts clinic operations. Any termination of the provider-patient relationship will be handled in accordance with applicable law and professional standards.

_____ _____

Signature of Patient / Responsible Party Date

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Consent to Audio Recording for Clinical Documentation

Print Patient Name _____ Birth Date (MM/DD/YYYY) _____

I understand and acknowledge that, from time to time, my healthcare provider may audio record portions of my visit solely for clinical documentation purposes, including assisting with medical record accuracy, transcription, and note-writing.

I understand that:

- Any audio recording will be used only for documentation related to my medical care and not for marketing, training, research, or any non-clinical purpose.
- Audio recordings are considered protected health information and will be safeguarded in accordance with applicable privacy laws, including HIPAA.
- Recordings will not be shared, published, or used outside the practice except as permitted or required by law.
- Recordings will be retained only as long as reasonably necessary to complete documentation and will then be securely stored or deleted in accordance with the practice's record retention policies.
- I may decline audio recording, and my decision will not affect my ability to receive care.

I HAVE READ, UNDERSTOOD, AND FULLY AGREE TO each of the above statements and sign below as my free and voluntary act.

_____ _____

Signature of Patient / Responsible Party Date