



# PATIENT HISTORY FORM

Please fill out the following confidential form for our records.

Patient Name: \_\_\_\_\_ Age: \_\_\_ Height: \_\_\_ Weight: \_\_\_ Shoe Size \_\_\_\_\_  
Current Foot or Ankle problem: \_\_\_\_\_  
\_\_\_\_\_

When did the problem start? \_\_\_\_\_  
What has been done to treat the problem? \_\_\_\_\_  
Are you now or have you ever been under a physician's care in the past two years? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Date last seen: \_\_\_\_\_  
Name of Former Podiatrist: \_\_\_\_\_ Date last seen: \_\_\_\_\_  
What conditions were you treated for:

## MEDICAL HISTORY

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney or Bladder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Gout	<input type="checkbox"/> Bleeding Disorders (sickle cell)	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Anemia/Blood	<input type="checkbox"/> Depression or Anxiety
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma/Bronchitis	<input type="checkbox"/> Vascular/Circulatory Disease
<input type="checkbox"/> Stroke or Heart Attack	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Stomach Ulcer / Reflux	<input type="checkbox"/> Accident/Injuries	<input type="checkbox"/> Foot Problems
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Immune Disease	<input type="checkbox"/> Other
<input type="checkbox"/> Liver Disease	(HIV, AIDS)	

Please explain any positive responses above (i.e. hepatitis for liver disease): \_\_\_\_\_  
\_\_\_\_\_

## MEDICATIONS, (please include dosage of each)

1) \_\_\_\_\_ 5) \_\_\_\_\_  
2) \_\_\_\_\_ 6) \_\_\_\_\_  
3) \_\_\_\_\_ 7) \_\_\_\_\_  
4) \_\_\_\_\_ 8) \_\_\_\_\_

## ALLERGIES, (penicillin, novocaine, tape, foods, etc.)

1) \_\_\_\_\_ 3) \_\_\_\_\_  
2) \_\_\_\_\_ 4) \_\_\_\_\_

## SURGERIES and HOSPITALIZATIONS (describe procedure, year and any complications)

1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_  
4) \_\_\_\_\_

## SOCIAL HISTORY

Occupation: \_\_\_\_\_ Tobacco: If yes, how much? \_\_\_\_\_  
Alcohol: If yes, how much? \_\_\_\_\_ Illicit drugs: If yes, how much? \_\_\_\_\_

**FAMILY HISTORY** (diabetes, heart disease, gout, cancer, foot problems or other): \_\_\_\_\_  
\_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

I hereby give Buehler Podiatry, permission to diagnose and administer treatment for my foot condition and authorize any release of information obtained in the course of my treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Financial Policy: All Patients Please Read and Sign**

**Payment is due at the time of service unless arrangements have been made in advance. If you are not prepared to pay for services rendered today, please notify the receptionist before you are seen by the doctor. We accept cash, checks, American Express, Discover, MasterCard, and Visa. Please see additional information below and sign at the bottom of the page.**

MEDICARE: We are a participating Medicare provider. Your fees will be based on what Medicare ALLOWS for our services. You will pay only your deductible if it is not met for the year, as well as your 20% co-payment on any charges beyond the deductible amount. You will also be asked to pay for any non-covered services. We will notify you ahead of time if the service to be performed is not covered by Medicare. If you have a secondary insurance we will file it for you on **SURGICAL PROCEDURES ONLY.**

HMO/PPO INSURANCE COMPANIES: If your insurance company is an HMO or PPO (Preferred Provider Organization) with whom we are associated, you will be required to pay based upon your policy guidelines. Co-payments and deductibles are due at the time of service. If your policy requires a referral from your primary care physician, it is your responsibility to obtain this and provide us with a copy. If your insurance company denies payment due to no referral, you will be responsible for paying our full fees. **WE MUST BE ABLE TO VERIFY YOUR INSURANCE COVERAGE BY TELEPHONE PRIOR TO YOUR APPOINTMENT. IF WE ARE NOTABLE TO DO SO, YOU WILL BE ASKED TO PAY OUR FULL FEES AT THE TIME OF SERVICE. IF COVERAGE IS LATER VERIFIED, WE WILL BE HAPPY TO REFUND YOU ANY OVERPAYMENT ONCE YOUR CLAIM HAS BEEN PROCESSED.**

SURGERY: We will file surgery charges with your insurance company, but the final responsibility for payment of all charges is ultimately yours - not your insurance company. If for any reason your insurance company does not pay as anticipated, you will be required to pay the balance. Prior to scheduling surgery, we may require a surgery deposit, depending upon your insurance coverage. This deposit will include pre-payment for any deductible, co-payment, and coinsurance amounts, as well as any non-covered services or supplies to be dispensed from our office.

Please sign that you have read, understand, and accept our financial policy. This signature also authorizes payment of insurance benefits to the physician and the release of medical records to process your claim (see below):

**Patient signature (parent, if minor): \_\_\_\_\_ Date: \_\_\_\_\_**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. BUEHLER OF THE SURGICAL AND MEDICAL BENEFITS OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES NOT PAID BY MY INSURANCE COMPANY. I ALSO AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS(S). THIS AUTHORIZATION SHALL BE VALID UNTIL REVOKED AND A PHOTOCOPY SHALL STAND AS THE ORIGINAL.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices from Dr. Buehler and that I have read (or have had the opportunity to read, if I so chose) and understood the Notice.**

**Signature of Patient or Legal Representative: \_\_\_\_\_**

**Date: \_\_\_\_\_**

**Buehler Podiatry**  
**3450 W. Wheatland #114**  
**Dallas, Texas 75237**

DATE: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the staff of Dr. Buehler to disclose information to the following person(s) about my procedures, as well as any other information concerning my health. I also authorize the following person(s) to receive information concerning my financial statement.

Name	Relationship	Date	Initial
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

**PLEASE NOTE:**

There will be times this office will call and leave messages regarding appointments and/or procedures.

This will be effective until I, \_\_\_\_\_, put in writing that I withdraw the above listed person (s).

Patient Signature (parent/guardian, if minor): \_\_\_\_\_ Date: \_\_\_\_\_