South Side FOOT & WOUND Specialist

1512 Pleasanton Rd. San Antonio, TX 78221
Phone: (210) 924 - 0516 **OR** (210) 924 -7553
Southsidefootandwound@gmail.com

Personal Information

Name: ______________________________

Last **First** **M.I.**

Address: ______________________________

Home Phone: ______________ Cellphone ______________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Gender ☐ Male ☐ Female Date of Birth: ______________

Contact of Emergency

Emergency Contact: ______________________________

Phone: ______________ Relationship: ______________

Insurance Information

Insurance Company: ______________ ID: ______________

Plan: ______________ Group: ______________

Name of the Policy Holder: ______________ Policy Holder's DOB: ______________

Primary Care Physician: ______________ PCP Phone: ______________

Preferred Pharmacy: ______________________ Pharmacy Phone: ____________________

Have you ever been seen by a podiatrist? ☐ Yes ☐ No

If yes, please fill out the bottom:

Name: ____________________ Last Visit: ______________ Reason: ____________________

Employment or School Information

Employment/School Status:

☐ Employed ☐ Full/Part Time ☐ Student ☐ Retired ☐ Disabled

Employer/School Name: ______________________________ Occupation: ________________

Work Phone: ____________________________ School Phone: ____________________________

Treat Consent and Liability of Payment For Service Required

I hereby consent and give any permission to the doctor (and the doctor's assistants) to administer such a procedure upon me as the doctor seems necessary. I, the undersigned, certify and I have insurance coverage as indicated and assign directly to the practicing physician all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially liable for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________________________________ ________________________________ ____________________

Signature of Patient, Parent/Guardian — Relation to Patient — Date

Allergies

Medications: ________________________________ Food: ____________________________

☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other: ______________________

Medical History:

Do you have any of the Following Medical Problem?

(Mark any that apply)

☐ Asthma	☐ Hepatitis	☐ Stomach Ulcers	☐ Sleep Apnea
☐ Cancer	☐ Headache	☐ Gout	☐ Hearing Ploblems
☐ Diabetes I, II, III Years: ________	☐ Bleeding Disorder	☐ Breathing Trouble	☐ Ankylosing Spondylitis
☐ Kidney Diseases	☐ Skin Problems	☐ Stoke	☐ Liver Diseases
☐ Vision Issues	☐ Heart Problems	☐ Blood Clots	☐ Constipation
☐ Psoriasis	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Other:

Do you take any medications? If so, please list bellow:

____

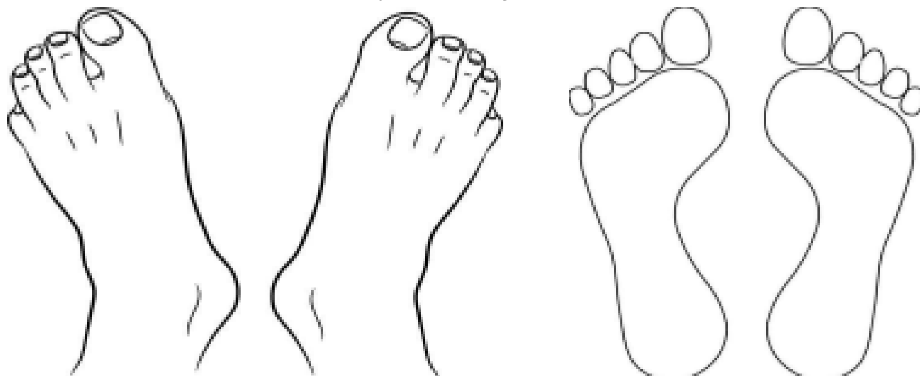
____

Current Problem

Which Foot are you having issues with?

☐ Left Foot ☐ Right Foot ☐ Both

(Mark where you are having the issues at)



How long ago did the pain or discomfort start? ______ Days/ Weeks/ Months/ Years

How would you rat ethe pain scale 0 (no pain) to 10 (worse pain)? ______

What makes your pain or problem feel better? ______

What treatments have you had for this problem? ______

Was this problem caused by an injury? ☐ **Yes** ☐ **No**

If yes, please describe:

______

______

The Importance of Giving Medical Information

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any change in my medical status.

______ ______ ______

Printed Name of Patient/Parent/ or Guardian Signature Date

Disclosure and Consent

Medical and Surgical Procedure

Patient's Name: ______

You have the right, as the patient, to be informed about your condition and recommend surgical, medical, or diagnostic procedures to be used so that you may make a formal decision.

I voluntarily request Southside Foot and Wound Care physician as my physician and such associates, technical assistants, and other health providers, as they may deem necessary, to treat any condition which has been explained to me as debridement (removal of necrotic tissue).

I understand that the following surgical, medical and/or procedures(s) are planned for me, and I voluntarily consent and authorize these procedures, serial sharps debridement of wound site(s) to health, viable tissue, with or without tissue biopsy, throughout this treatment course. I understand the physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I understand that no warranty or guarantee has been made to me as to result and/or cure and that I may withdraw my consent at any time prior or treatment.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I realize that similar procedures common to surgical, medical and/or diagnostic techniques have the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reaction, and even death. I also realize that the following risks and hazards may occur in connection with this procedure: Cleaning, curettage and/or debridement.

I understand that anesthesia (local) involves additional risks and hazards and requests the use of an aesthetics (if needed) for the relief and protection from pain during the planned and additional procedures.

Signature of Patient, or Other Parties Responsible for Patient Date