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Bryan J. Prukop, DPM
Thomas E. Brooks, DPM
Oscar Corral, DPM

812 Lindberg Ave, McAllen, Texas 78501
Phone: (956) 971-9107 Fax: (956) 971-9109

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Phone: (956) 585-2244 Fax:(956) 585-4229

PATIENT AND GUARANTOR INFORMATION
(PLEASE PRINT CLEARLY)

PATIENT INFORMATION

PATIENT NAME:	SEX:	AGE:	DATE OF BIRTH:
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	OTHER CONTACT NUMBER:		
SOCIAL SECURITY NUMBER:			
EMAIL ADDRESS (OPTIONAL):			

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)

PATIENT NAME:	SEX:	AGE:	DATE OF BIRTH:
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	WORK PHONE NUMBER:		
SOCIAL SECURITY NUMBER:			
GUARANTOR AND POLICY HOLDER THE SAME PERSON? YES____ NO____			
GUARANTOR EMPLOYER:			
EMPLOYER ADDRESS:	CITY:	STATE:	ZIP CODE:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:			
ADDRESS:	CITY:	STATE:	ZIP CODE:
POLICY NUMBER:	GROUP NUMBER:		
SECONDARY INSURANCE NAME:			
ADDRESS:	CITY:	STATE:	ZIP CODE:
POLICY NUMBER:	GROUP NUMBER:		

_________________________ REFERRED BY

___________________ Date

Revised 12/2014

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PLEASE PRINT CLEARLY

HOW DO YOU DESCRIBE YOUR FOOT/FEETPROBLEM(S)?

____

____

HOW LONG HAVE YOU HAD THIS/THESE PROBLEM(S)?____

WHAT TREATMENTS HAVE YOU HAD FOR THIS/THESE PROBLEM(S)?

____

HAVE ANY OF THE ABOVE TREATMENTS HELPED AT ALL?

____

Primary Care Physician:_________________**Cardiologist:** _________________**Pharmacy:**_________________

Past Medical History

____ Cholesterol ____Diabetes For How Long?:_____Yrs____Months ___High Blood Pressure ___Heart Disease
____Arthritis ____Dialysis
____Hypertension ____Thyroid ____Cancer____Other: __________ ______________ ____________

Medicines	**Allergies**	**Surgeries**	
____Glucophage	____Penicillin	____Appendectomy	____Hysterectomy
____Insulin	____Coumadin	____Heart Bypass	____Cataract
____Crestor	____Tylenol	____Cholecystectomy	____ Cesarean
____Plavix	____Aspirin	____Leg Bypass	____ Mastectomy
____Amlodipine	____Sulfa	____Gallbladder	____ Dialysis Graft
____Lipitor	____Betadine	____Glaucoma	
____Aspirin	____Neosporin	____Foot Surgery:______________________________	
____Glucovance	____Iodine		
____Pletal	____Shellfish, Shrimp		
____Coumadin	____ Other: ________________	Other: ______________	
____Actos			
____Trepal			
____Lasix			
____Glucovance			
____Glipizide			
____Glyburide			
____Captopril			

____Other: ______________ Other: ________________Other: __________________ Other: _______________

SOCIAL HISTORY (*Please Check*)

Marital Status: ____Married___Single___Widowed___Divorced___Separated
Education: ___High School Graduate___College ___Other
Smoker: ___Yes___No How Much? ___________ Alcohol:___Yes___No
Occupation:___Full-Time___Part-Time___Self-Employed___Not Employed ____Retired
Profession/Employer: ____
Illicit drugs:___Yes___No If Yes, Marijuana/Cocaine/Other: ________________________________

FAMILY HISTORY *Please Check*

Hypertension: ___Yes___No *Mom__Dad__ Grandfather__Grandmother__ Aunt__Uncle__*
High Cholesterol:___Yes___No *Mom__Dad__ Grandfather__Grandmother__ Aunt__Uncle__*
Coronary heart disease:___Yes___No *Mom__Dad__ Grandfather__Grandmother__ Aunt__Uncle__*
Diabetes: __Yes__No *Mom__Dad__ Grandfather__Grandmother__ Aunt__Uncle__*
Cancer: __Yes__No *Mom__Dad__ Grandfather__Grandmother__ Aunt__Uncle__*
Other mental illness:___Yes____No *Mom__Dad__ Grandfather__Grandmother__ Aunt__Uncle__*
Other: _______________*Mom__Dad__ Grandfather__Grandmother__ Aunt__Uncle__*

________________________________ ____________________
Patient's Name **Date**

Revised 12/2014

Complete Family Foot Care
"Take the First Step to a Healthier You"

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MEDICAL HISTORY REVIEW OF SYSTEMS

Please check any of the following that currently apply to you:

Constitutional: _____ fever_____ chills _____ weakness _____ weight loss

Eyes: ____ double blurred vision ____ dry ____ redness ____ pain

Ear/Nose/Mouth/Throat: ____ ear pain ____ nasal congestion ____ bloody gums ____ sneezing

Cardiovascular: ____ chest pain ____ swelling ____ palpitations ____ cold feet ____ cold hands

Respiratory: ____productive(phlegm) ____coughing up blood ____bloody spit ____ wheezing cough

Gastrointestinal: ____ nausea ____ vomiting ____ heartburn ____ constipation

Genitourinary: ____ incontinence ____ blood in urine ____ vaginal discharge

Bones/Muscles: ____difficulty walking/sitting/standing ____ unsteady on your feet ____swollen feet ____ muscle weakness

Skin/Breast(Including Men): ____ rash ____ breast pain ____nipple discharge ____lumps

Neurologic: ____ seizures ____ temors ____ tingling ____ numbness

Psychological: ____ usually stressed ____ depressed ____ nervousness ____ trouble sleeping

Endocrine: ____usually tired ____ usually hungry or thirsty ____unexplained weight loss ____ recent hair loss

Name: ______________________________ **Date:** ______________________

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:________________________________ Medical Record Number_____________________
Social Security Number ___________________________ Date of Birth __________________________

I authorize Complete Family Foot Care to make the disclosure.

The type and amount of information to be used or disclosed is as follows: (include dated where appropriate)
_____ Physical Progress Notes _______________ (dates)
_____ History & Physical ___________________(dates)
_____ Laboratory Results ___________________ (dates)
_____ Radiology Results ___________________ (dates)
_____ Operative Reports ___________________ (dates)
_____ Entire Record _______________________ (dates)
_____ Other (Relative)____

1. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

2. This information may be disclosed to and used by following individuals or organization

   ____ **COMPLETE FAMILY FOOT CARE**
   812 LINDBERG AVE.
   MCALLEN, TX 78501

   _____**COMPLETE FAMILY FOOT CARE**
   1922 E. GRIFFIN PARKWAY, STE D
   MISSION, TX 78572

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Office Manager. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contact a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date event or: __________________ condition. If I fail to specify an authorization date, event or condition, this authorization will expire in 180 days.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need sign this form on order to ensure treatment. I understand that I may inspect or request a copy of the information to be used or disclosed as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re- disclosure and the information may not be protected by federal confidentiality rules.

____ ____________________
Signature of Patient or Legal Representative Date

____ ____________________
If Signed by Legal Representative, Relationships to Patient Date

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Acknowledgement of Receipt
Of
NOTICE OF PRIVACY PRACTICE

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

___________________________________ _____________

Patient Name (Please Print) **Date of Birth**

____

Parent or Authorized Representative (if applicable)

____

Signature

- -

RECONOCIMENTO DE HABER REVISADO
EL AVISO ACERCA DE LAS PRACTICAS DE PRIVACIDAD

Yo he revisado el Aviso de las Privacidad, la cual explica como se puede Utilizar la informacion de salud individual indetifiable. Yo comprendo que tengo el derecho de recibir una copia de este documento.

___________________________________ _______________

Firma del Paciente o Guardian Legal **Fecha de Nacimiento**

____

Nombre del Paciente o del Representate Personal

____

Descripion de la Authoridad del Reprentante Personal

Revised 12/2014