PATIENT INFORMATION AND HISTORY

NAME: First_____ MI _____ Last_____

EMAIL: _____

DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT:_____

RACE: _____ ETHNICITY: Non-Hispanic/Latino OR Hispanic/Latino SEX: Male / Female

HOW DID YOU FIND US? _____

REASON FOR TODAY'S VISIT? _____

PRIMARY CARE DR/PHONE #: _____LAST SEEN _____

PHARMACY NAME: _____PHONE # _____

PHARMACY ADDRESS: _____

MEDICATIONS: List current medications & dosage _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: None ____ Medication Allergies? _____

Any other allergies, including food? _____

PAST MEDICAL HISTORY: If you now have or have ever had any of the following conditions, please circle:

Anemia	Cancer	Headaches	Phlebitis
Anxiety	Depression	Hearing disorders	Rheumatism
Arthritis	Diabetes:	Heart disease	Seizure disorders
Asthma	Type 1 or Type 2	Hepatitis	Skin disorders
Bipolar disorder	# of years? _____	High blood pressure	STD's
Bleeding disorders	Drug/Alcohol dependency	High cholesterol	Stroke
Blood clots	Eye disorders	HIV/AIDS	Thyroid disorders
Children/Pregnancies	Gastrointestinal disorders	Lupus	Urinary disorders
Circulation disorders	Gout	Neuromuscular disease	Other_____

FAMILY HISTORY: list any medical conditions that run in your immediate family:

Mother: _____

Father: _____

HOSPITALIZATIONS/SURGERIES: List all previous surgeries, begin with the most recent - include month / year.

_____

_____

SOCIAL HISTORY: Circle or fill in all that apply

Married
Single
Divorced
Widowed

Alcohol Intake: _____ Caffeine Intake: _____ cups per day

Circle One: Non-Smoker Previous smoker Current Smoker, _____ packs per day

Retired: _____Yes _____No Even if retired, please tell us your previous occupation below.

Occupation: _____

Signature _____ Date _____

Name_____

Address_____

City_____ State _____ Zip Code _____

Home Phone_____ Work Phone _____ Cell Phone _____

Employer_____ Occupation _____

Nearest Relative/Friend_____
First Name Last Name Phone Number

THE FOLLOWING SECTION MUST BE FILLED OUT FOR INSURANCE PURPOSES

Medicare: Yes _____ No _____ Medicare Replacement Plan: Yes _____ No _____

Primary Insurance Co. _____ ID # _____ Group # _____

Policy Holder's Name_____ SS# _____
First Name Middle Initial Last Name

Policy Holder's
Birthdate _____/_____/_____ Patient's Relationship to Insured: Self Spouse Child Other

Insured's Address: Same as patient's _____ other: _____

Insured's Phone number: Same as patient's _____ other: _____

Secondary Insurance Co. _____ ID # _____ Group #_____

Insured's Name_____ SS# _____
First Name Middle Initial Last Name

Birthdate _____/_____/_____ Patient's Relationship to Insured: Self Spouse Child Other

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Jill Wisdom, DPM, to release and furnish on a confidential and strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality PPO's , managed care organizations, IPA's, Medicare/Medicaid or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions.

Signature of Patient/Responsible Party _____ Date _____

PLEASE GIVE US YOUR INSURANCE CARD AND PHOTO ID

Jill C. Kranzow, DPM PA
Jill C. Wisdom, DPM
6309 Preston Rd., Suite 1200
Plano, TX 75024
(972) 769-7280

This paper is to serve as notification that Dr. Wisdom is an investor in the following businesses:

Up and Open MRI
Surgery Center of Craig Ranch

_____
Please initial

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment (copays and supplies), unless other Arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility. I understand that filing a claim with my insurance does not relieve me from my responsibility for the payment of charges. I acknowledge that payment arrangements are expected at the time a statement is received.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Printed Name of Patient, Parent, Guardian or Personal Representative

_____
Date

Jill C. Kranzow, DPM PA

Jill C. Wisdom, DPM
6309 Preston Rd., Suite 1200
Plano, TX 75024
(972) 769-7280

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Jill C. Kranzow, DPM PA Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information.

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI to anyone other than my referring provider Jill C. Kranzow, DPM PA must have my consent. Therefore, I authorize Jill C. Kranzow, DPM PA to disclose my PHI as described on this form to the recipients listed below:
(Some examples of named authorized persons may be physicians other than your referring doctor, family members or other specified persons.)

Name _____ Relationship to Patient _____ Phone Number _____

Name _____ Relationship to Patient _____ Phone Number _____

OR

☐ DO NOT disclose or discuss any information related to my medical condition or account information with anyone other than myself.

Contact Information

** Please include phone number: _____

When contacted by phone regarding my medical condition or upcoming appointments, please use the following option:

☐ OK to leave a message with detailed information. ☐ Leave a message with a call-back number only.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed on this form will require my specific authorization prior to the disclosure of any medical information.

Printed Name of Patient, Parent, Guardian or Personal Representative _____ Date _____

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____