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	Alcohol Intake: ______________________	Caffeine Intake: ____________________ cups per day		
Single	Circle One:	Non-Smoker	Previous smoker	Current Smoker, ________ packs per day
Divorced	Retired: ______Yes ______No Even if retired, please tell us your previous occupation below.			
Widowed	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 Plano
Surgery Center of Craig Ranch
Summit Physical Therapy

____
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