

Past Medical History

Dr. Mantzoros/Dr. Gordon

Today's Date _____

Name _____ Sex _____ Date of Birth ____/____/____

Age _____ Height _____ Weight _____ Shoe Size _____

Occupation _____

Chief Complaint _____

Onset: Sudden _____ Gradual _____ Previous Fractures/Dislocations _____

Current Health Good _____ Fair _____ Poor _____

Currently Seeking Medical Care Yes _____ No _____ Why _____

- | | | | |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure Disorders | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Circulatory Disease | <input type="checkbox"/> Hypertension (High B/P) | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hypotension (Low B/P) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Gout |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Pregnant | Other _____ | |

Allergies:

- | | | |
|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Foods | <input type="checkbox"/> Sulphites | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulphur | <input type="checkbox"/> Tape |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthesia | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Novocain | _____ |

Past Surgical History:

Surgery	Date	Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Present Medications

Medications	Illness	Medications	Illness
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: Diabetes Hypertension Bleeding Disorder Circulatory
 Arthritis Problem with Anesthesia

Social History: Tobacco (Pks/Day) _____ Coffee/Tea (Cups) _____ Alcohol _____

Do you take aspirin regularly? _____ Do you faint easily? _____

INSURANCE AUTHORIZATION/PAYMENT POLICY

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance company(ies), and assign directly to Dr. Mantzoros/Dr. Gordon all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions:

_____ Date _____
Responsible Party Signature

Medicare Authorization (If Applicable)

I request that payment of Medicare benefits be made on my behalf to Dr. Mantzoros/Dr. Gordon for any services furnished me by that physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the carrier.

_____ Date _____

Payment Policies

All copays, deductibles, and coinsurance are due at the time of service. If you belong to an HMO, you will need a referral. If you belong to a PPO, you may have a deductible. Remember, it is your responsibility as a patient to get a referral if one is required. If you do not have one, you will be responsible for out-of-network benefits. Please let the receptionist know if you have new insurance at your time of arrival.

Insurance Release/Authorization

I understand that for medical/legal purposes and by Texas State Law, X-rays and medical records taken/created by this office are the property of Dr. Mantzoros and Dr. Gordon. I also understand that all charges for services are due and payable at the time the services are rendered. We accept cash, checks, Mastercard, Visa and Discover.

I agree to be responsible for the charges on this account.

_____ Date _____
Patient or Guardian

**CONROE FOOT SPECIALIST
DR. D. S. MANTZOROS, D.P.M.
DR. M. L. GORDON, D.P.M.
DR. S. FAYSAL. D.C.**

DATE _____

I, _____, hereby authorize the staff of Dr. Mantzoros, Dr. Gordon, and Dr. Faysal 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).

Signature

Date