

NORTH TEXAS FOOT CARE ASSOCIATES
3415 LOY LAKE RD
SHERMAN, TX 75090

Medical Alerts or Medication Allergies	Patient Name		Male	Female	Today's Date	
	Mailing Address			City	State	Zip
	Physical Address					
	Home Phone #		Social Security #		Birthdate	Age
	Employer			Occupation		Business Phone / Ext
	Cell Phone #			Other Cell Phone #		
Marital Status	Spouse Name			Spouse Social Security #		
Spouse Employer			Birthdate		Business Phone / Ext.	
If A Minor, Parent / Guardian Name		Address, if Different From Above			Phone	
Parent / Guardian Employer			Birthdate		Business Phone / Ext.	
Primary Insurance Carrier / Medicare		Employee (Covered Person)		Group #	Emp. I.D. #	
Mailing Address			Employee Birthdate	Phone #		
Secondary Insurance Carrier		Employee (Covered Person)		Group #	Emp. I.D. #	
Mailing Address			Employee Birthdate	Phone #		
Family Physician		Former Podiatrist (if any)		Podiatric Treatment	How Long Ago?	
Referred By		Chief Complaint Today				

Please list any medical conditions you have (allergies, impairments, etc.):

	Yes	No	Comments
Is your general health good?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any serious illnesses or operations?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any injuries or operations on your feet or legs?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have bleeding tendencies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had leg cramps?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any family members been treated for diabetes?	<input type="checkbox"/>	<input type="checkbox"/>

Check (✓) any of the following that you have had treatment for:

- Heart Problems
 Asthma
 Epilepsy
 Diabetes
 Rheumatic Fever
 Kidney Problems
 Liver Problems
 Arthritis
 Bursitis
 High Blood Pressure
 Low Blood Pressure
 Other - what? _____

Height _____ Weight _____ Shoe Size _____

I hereby give John S. Sciortino, D.P.M or Thomas L. Flick, D.P.M. permission to examine and treat my feet.

Patient's Signature _____

If a minor, parent or guardian's signature _____

Relationship to minor _____

NORTH TEXAS FOOT CARE ASSOCIATES, P.A.

**3415 Loy Lake Road
Sherman, Texas 75090
Telephone: (903) 893-9661
Fax: (903) 868-2975**

**JOHN S. SCIORTINO, D.P.M.
THOMAS L. FLICK, D.P.M.**

*** Diplomate of the American
Board of Podiatric Surgery**

MEDICAL INFORMATION RELEASE

I authorize North Texas Foot Care Associates, P.A. and staff to review my medical history, prescriptions, and insurance information for the purpose of providing medical and/or surgical treatment. I authorize the physicians and their staff to release any information needed to determine these benefits payable for related services. I also authorize North Texas Foot Care Associates, P.A. and staff to furnish a copy of my medical records to any entity that provides my written consent.

INSURANCE ASSIGNMENT

I hereby authorize the staff of North Texas Foot Care Associates, P.A. to bill my insurance company(ies) for any services, materials, and supplies which are furnished to me in conjunction with my medical and/or surgical treatment. I authorize payment directly to North Texas Foot Care Associates, P.A. of the surgical and/or medical benefits, if any, otherwise payable to me. I understand I am responsible to the physicians for charges not covered by this agreement.

FOR OUR PATIENTS INFORMATION

Some insurance companies now require a referral number or form to see anyone but your primary care physician (PCP). Please check your policy or call your company prior to your visit with us. If a valid referral is not on file, you will be responsible for the charges at the time of the visit.

Signature of Patient

Date