PATIENT REGISTRATION

LAST NAME: ________________________________ FIRST NAME: ________________________ MI: ________

DATE OF BIRTH: ____________________ SEX: ___________ SOCIAL SECURITY #: _______________________

RACE: ________________ETHNICITY: _______________________ MARITAL STATUS: ___________________

ADDRESS 1: ____

CITY: _________________________ STATE:_____________ ZIP: __________________

LANGUAGE: __________________ How did you hear about us? ______________________________________

EMPLOYMENT STATUS: EMPLOYED UNEMPLOYED STUDENT RETIRED

OCCUPATION:______________________________ EMPLOYER:_______________________________________

CONTACT INFORMATION

HOME PHONE: ____________________________ WORK PHONE: ____________________________ EXT:_____

CELL PHONE: __________________________ EMAIL: _______________________________________

EMERGENCY CONTACT INFORMATION

NAME: ____ PHONE: _________________________________

RELATIONSHIP TO PATIENT: _______________________

PRIMARY CARE / OTHER PHYSICIAN

PRIMARY CARE (PCP) NAME: ____

CITY: __________________ STATE: ___________ LAST VISIT WITH PCP: ________________________________

PHARMACY INFORMATION

PHARMACY NAME: _______________________________ PHARMACY PHONE: ______________________

PHARMACY LOCATION/INTERSECTION: ____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate.

Patient/Guarantor Signature: __________________________________ Date: ___________________

LAST NAME: ____________________________ FIRST NAME: _______________________ DOB: ___________ DATE: __________

REASON FOR TODAY'S VISIT	

REVIEW OF SYSTEMS

CONSTITUTIONAL			MUSCULOSKELETAL			NEUROLOGICAL		
FEELING SICK	Y / N		LOW BACK PAIN	Y / N		DIZZY	Y / N	
FATIGUE	Y / N		PAIN IN LEGS	Y / N		DISORIENTED	Y / N	
FOOT PROBLEM RELIEVED WITH REST	Y / N		PAIN IN FEET	Y / N		BALANCE ISSUES	Y / N	
FEVER	Y / N		JOINT PAIN	Y / N		HEADACHES	Y / N	
EYES & EARS			BONE PAIN	Y / N		SEIZURES	Y / N	
GLASSES/CONTACTS	Y / N		GENERAL MUSCLE PAIN / ACHE	Y / N		TREMORS	Y / N	
EYE PAIN	Y / N		SWELLING IN LEGS	Y / N		FEET FALL ASLEEP OFTEN	Y / N	
RINGING IN EARS	Y / N		SWELLING IN JOINTS	Y / N		NUMBNESS OR BURNING IN FEET	Y / N	
CARDIOVASCULAR			STIFFNESS IN JOINTS	Y / N		CRAMPS WHEN WALKING	Y / N	
SWELLING IN LEGS	Y / N		CHANGES IN GAIT (WALK)	Y / N		PAIN IN FEET, RESTING	Y / N	
VARICOSE VEINS	Y / N		DIFFICULTY CLIMBING STAIRS	Y / N		PAIN IN FEET, ALL THE TIME	Y / N	
LEG CRAMPS WITH REST	Y / N		LOSS OF STRENGTH IN LEGS	Y / N		SHOOTING PAIN IN LEGS	Y / N	
LEG CRAMPS WITH WALKING	Y / N		RIGIDITY IN LEGS	Y / N		LEG PARALYSIS	Y / N	
COLD FEET	Y / N		LIMP WHEN WALKING	Y / N		**PSYCHIATRIC**		
RESPIRATORY			**INTEGUMENTARY**			PSYCHIATRIC ILLNESSES	Y / N	
CHEST PAINS	Y / N		SKIN PROBLEMS	Y / N		DEPRESSION	Y / N	
DIFFICULTY BREATHING	Y / N		SUN SENSITIVITY	Y / N		BI-POLAR	Y / N	
SHORTNESS OF BREATH	Y / N		SKIN RASHES	Y / N		ANXIETY	Y / N	
GASTROINTESTINAL			WARTS ON FEET	Y / N		MOOD SWINGS	Y / N	
LOSS/INCREASE OF APPETITE	Y / N		MOLES, LUMPS, OR BUMPS	Y / N		UNDER STRESS	Y / N	
STOMACH ULCERS	Y / N		DRY SKIN	Y / N		**ENDOCRINE**		
FREQUENT HEARTBURN	Y / N		OPEN SORES	Y / N		LOST / GAINED WEIGHT	Y / N	
STOMACH PROBLEMS	Y / N		SKIN DISCOLORATIONS	Y / N		EXCESSIVE THIRST	Y / N	
BLOODY OR DARK STOOL	Y / N		CORNS AND CALLOUSES	Y / N		NIGHT SWEATS	Y / N	
GASTROURINARY			THICK NAILS	Y / N		SWOLLEN GLANDS	Y / N	
FREQUENT URINATION	Y / N		DEFORMED NAILS	Y / N		**HEMATOLOGY**		
PAIN WITH URINATION	Y / N		INGROWN NAILS	Y / N		BRUISE EASILY	Y / N	
BURNING WITH URINATION	Y / N					**IMMUNOLOGY**		
BLOOD IN URINE	Y / N					SLOW HEALING WOUNDS	Y / N	

PATIENT SIGNATURE:

LAST NAME: ____________________________ FIRST NAME: _______________________ DOB: ___________ DATE: __________

PAST MEDICAL, FAMILY, SOCIAL HISTORY

LOWER EXTREMITY

ANKLE PAIN	Y / N
ATHLETE'S FOOT	Y / N
BUNION	Y / N
CORNS & CALLOUSES	Y / N
CRAMPS IN LEGS / FEET	Y / N
FLAT FEET	Y / N
HEEL PAIN	Y / N
INGROWN TOENAILS	Y / N
NUMBNESS IN LEGS / FEET	Y / N
PLANTAR WARTS	Y / N
SWELLING IN ANKLES / FEET	Y / N

PAST MEDICAL HISTORY

ANEMIA	Y / N
ANESTHETIC REACTION	Y / N
ARTHRITIS	Y / N
ASTHMA	Y / N
BLEEDING DISORDERS	Y / N
CANCER: __________________	Y / N
CIRCULATION PROBLEMS	Y / N
DIABETES TYPE: I II	Y / N
STROKE	Y / N
EPILEPSY	Y / N
GOUT	Y / N
HEART DISEASE	Y / N
HEPTATITIS	Y / N
HIGH BLOOD PRESSURE	Y / N
HIGH CHOLESTEROL	Y / N
HIV/AIDS	Y / N
KIDNEY DISEASE	Y / N
LIVER DISEASE	Y / N
MITRAL VALVE PROLAPSE	Y / N
NAIL DISORDERS	Y / N
NERVE DISORDERS	Y / N
PHLEBITIS	Y / N
PULMONARY DISEASE	Y / N
SKIN PROBLEMS	Y / N

PAST MEDICAL HISTORY (CONTINUED)

PREVIOUS SURGERIES:	DATE/YEAR
_________________________	__________
_________________________	__________
_________________________	__________
_________________________	__________
_________________________	__________

ALLERGIES

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____

____

MEDICATIONS

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FAMILY HISTORY

FATHER

ALIVE / DECEASED (CAUSE: _______________)

ILLNESSES: ______________________________

____

GENERAL HEALTH: **EXCELLENT / GOOD / FAIR / POOR**

MOTHER

ALIVE / DECEASED (CAUSE: _______________)

ILLNESSES: ______________________________

____

GENERAL HEALTH: **EXCELLENT / GOOD / FAIR / POOR**

SIBLING(S)

NUMBER OF SIBLINGS ________________

ILLNESSES: ______________________________

____

____

GENERAL HEALTH: **EXCELLENT / GOOD / FAIR / POOR**

FAMILIAL DISEASES

CARDIOVASCULAR DISEASE	Y / N
HEART ATTACK	Y / N
STROKE	Y / N
HIGH BLOOD PRESSURE	Y / N
ELEVATED CHOLESTEROL	Y / N
DIABETES	Y / N
ASTHMA / HAY FEVER	Y / N
CONGENITAL HEART DISEASE	Y / N
GLAUCOMA	Y / N
OBESITY	Y / N
LEUKEMIA/CANCER	Y / N

OTHER:___________________________

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SOCIAL HISTORY

EXERCISE	Y / N
SEXUALLY ACTIVE	Y / N
PREGNANT	Y / N
TOBACCO USE	Y / N
MARIJUANA USE	Y / N
RECREATIONAL DRUG USE	Y / N
ALCOHOL USE	Y / N
CAFFEINE	Y / N

LEVEL OF EDUCATION: _______________

____

OCCUPATION: ______________________

OTHER

PATIENT SIGNATURE:

Practice Policies Effective January 1, 2020

PATIENT NAME: ____ DOB: _________________________

FINANCIAL POLICY: Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsibly party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.
COPAYMENTS: It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.
DEDUCTIBLES & CO-INSURANCE: If you have a high deductible plan, we may collect a deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.
SELF-PAY: Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the doctor but you will be informed of these charges before proceeding with treatment.
REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.
NO SHOW: 24 hours notice is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours-notice** of a procedural visit will incur a **$100** fee.
SURGERY CANCELLATION: Failure to provide **5 business days** notice of cancellation prior to scheduled surgery date will incur a **$500** fee.
BALANCES/COLLECTION FEES: If balance is not collected within 30 days from the postmark date of a mailed statement, a **$12** re-billing fee will be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a **$35** administrative fee will be added. We accept cash, checks, and all major credit cards.
FMLA / DISABILITY / MEDICAL RECORDS: Fees for medical records are as follows: **$25** charge for completion of ***FMLA and disability forms***; **$25** fee for a copy of your ***medical records*** (pages 1-20), **plus an additional $.50 per page** thereafter; **$25** fee for digital x-ray copies on CD; **$25** fee for other medical forms requested; Postage and delivery are at the expense of the patient and will also include a **$15** administrative fee.
PRIVACY POLICY: I acknowledge that I have been able to view the NOTICE OF PRIVACY PRACTICES in the office of Dr. David Jenson. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice, others, or myself.
INFORMED CONSENT: I understand that the information sent to me via email and/or text message from persons at JENSON Foot & Ankle Specialist will not be sent securely and will be unencrypted. I understand the risks associated with that; including but not limited to, that my PHI may be read by an unintended third party. I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via email and text message as is convenient or necessary for certain communication with staff members. I understand that JENSON Foot & Ankle Specialist, and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text. I further understand that I bear the risk.
PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST: The purpose of the disclosure notice is to inform you that JENSON Foot & Ankle Specialist has financial interests in Essential Imaging Center, Surgery Center of The Woodlands, and North Houston Medical Center. You have the right by law to choose the provider of your health care services. You will not be treated differently by your physician if you choose to obtain imaging services or have surgery at another facility. We welcome you as a patient and value our relationship with you.

I have read and understand the above financial policy, privacy policy, informed consent statement, and physician disclosure of financial interest notice.

Patient/Guarantor Signature: ___________________________________ Date: ____________________

RELEASE OF MEDICAL RECORDS

(For immediate family only)

PATIENT NAME: ___________________________________

TODAY'S DATE: ___________________________________

DATE OF BIRTH: ___________________________________

I, the above patient, give permission to the office of David Jenson DPM, to provide any information regarding my medical records, including but not limited to, office notes, x-rays, lab results and billing information to the following recipients: (if no release is permitted, circle N/A)

N/A

NAME: ___________________________________ RELATIONSHIP TO PATIENT: ________________________

NAME: ___________________________________ RELATIONSHIP TO PATIENT: ________________________

NAME: ___________________________________ RELATIONSHIP TO PATIENT: ________________________

According to Health and Human Services, this release does not limit our ability to send your medical records to covered entities for treatment, payment, or health care operations. This includes, but is not limited to, sending information to your pharmacy for prescription orders, communicating with your insurance plan to reimburse your charges, and disclosing with appropriate legal requests.

To make any changes to your release, please submit your request in writing to our office. Record requests may take up to 7-10 business days to complete and may be subject to a fee.

By signing below, you state you understand the release notice above and have opted to release or not release your medical records from our office.

Patient/Guarantor Signature: __________________________________ Date: ___________________

YOUR RIGHTS AND RESPONSIBILITES AS A PATIENT AND CONSENT TO TREAT:

You have the right to:

- Receive clear and accurate information about your benefits rights and responsibilities, and information on all of these services offered to you
- Be treated with respect and dignity
- Your privacy, and that your personal health information be kept secure and confidential.
- Be involved with the doctor and other health care professionals in the decision making process regarding your health care.
- Have a clear and open talk with your health care professional about appropriate care for your condition regardless of cost or whether it is covered by your health plan benefits.
- Refuse treatment and be informed of the probable consequences of your actions.
- Receive appropriate information so that you may give informed, voluntary consent to participate in research.
- Have your guardian, next of kin, or legally authorized person exercise your rights on your behalf if your medical conditions make you incapable of understanding or exercising your rights.
- Receive advice or assistance in prompt, courteous, and responsible manner.
- Be given the first name of any staff member involved in your case and speaking with their immediate supervisor if desired.
- Make a written or verbal suggestion or complaint about the care you receive.

You have responsibility to:

- Give patient identification and medical information, to the best of your ability, so that your physician can properly care for you.
- Follow the prescribed medical plan and health care instructions that you have agreed upon with your doctor.
- To the best of your ability, work with your doctor to be aware of and understand your health problems, and participate in developing your health care treatment goals.
- Keep you appointments, or tell the doctor ahead of time if you will be late or need to cancel.
- Pay any applicable co-pay, co-insurance, and deductibles at the time you receive service.
- Understand what medications you are taking and whether follow-up care is needed.
- Treat those caring for you with respect and courtesy.
- Express your opinions, concerns, or complaints in a constructive manner to appropriate people.

CONSENT FOR MEDICAL TREAMENT:

By signing below, I acknowledge that I voluntarily consent to medical treatment and procedures that may be performed on me during all healthcare visits now and in the future that is deemed medically necessary in order to treat the condition and/or conditions by the Dr. David Jenson and this includes, but is not limited to medical treatment, physical therapy, surgical care, x-ray, test, medications, laboratory test and/or other serves.

I am aware of my right and responsibilities and consent for treatment.

Name:______________________________ ***Signature:***_________________________________

DOB:_________________

Date:________________