David H. Korfin DMP, PA

Fellow, American College of Foot and Ankle Surgeons
Diplomate, American Board of Foot and Ankle Surgery
1327 Lake Pointe Pkwy, Suite 510
Sugar Land Texas 77478
Office (281) 313-3338 / Fax (281) 313-3313

ALL INFORMATION IS STRICTLY CONFIDENTIAL / ***PLEASE PRINT NEATLY!! ***

PATIENT NAME:_____ GENDER: M F

HOME ADDRESS:_____
Street Apt# City, State, Zip

DATE OF BIRTH:_____

HOME PHONE #: _____ WORK PHONE #:_____x _____

CELL PHONE #: _____ E-MAIL ADDRESS: _____

MARITAL STATUS: M S W D PREFERRED LANGUAGE: _____

RACE _____

EMPLOYMENT STATUS:_____ EMPLOYER: _____

WHO REFERRED YOU TO OUR OFFICE?: _____

SPOUSE OR PARENT:

NAME: _____ DOB: _____ NUMBER: _____

EMERGENY CONTACT (Other than spouse)

NAME: _____ RELATIONSHIP: _____

TWO CONTACT NUMBERS: 1. _____ 2. _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I knowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name/Signature (please print) Date

_____
Parent or Authorized Representative

****

As your physician, I believe that you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, I provide this notification that I hold an ownership interest in:

Elite Center for Minimally Invasive Surgery of Oak Bend
Compound RX
National Interventional Radiology Partners

By my signature below, I hereby acknowledge that I have received notification of Dr. Korfin's ownership interests.

Patient Signature _____

MY FOOT PROBLEM IS _____ HOW LONG? _____

Are you currently taking any medications:

Name of Medication	Dosage	Prescribing Physician

Check any of the following you HAVE HAD or NOW HAVE:

____ DIABETES	____EPILEPSY (SEIZURE)	____LOW BACK PAIN	____LIVER PROBLEMS
____ CANCER	____TUBERCULOSIS	____STOMACH ULCERS	____BLOOD PROBLEMS
____ GOUT	____SHORT OF BREATH	____FAINTING SPELLS	____POOR CIRCULATION
____ KIDNEY PROBLEMS	____PRONE TO INFECTION	____PHLEBITIS	____VARICOSE VEINS
____ HIGH BLOOD PRESSURE	____HEART TROUBLE	____LEG CRAMPS	____HEPATITIS
____ ANEMIA	____ARTHRITIS	____UNEQUAL LEG LENGTH	____HIV (AIDS)
____ ASTHMA	____SICKLE CELL	____STROKE	____ARTIFICAL JOINTS
____GLAUCOMA	____BLEEDING TENDENCY	____MITRAL VALVE PROLAPSE	
____ THYROID	____ SKIN PROBLEMS	____ REFLUX	____DEMENTIA
____ NEUROLOGIC DISORDER	____ ELEVATED CHOLESTEROL	___ DEPRESSION/ANXIETY	
____OVER-ACTIVE BLADDER	____ ADHD	____ OTHER _____	

ANY KNOWN ALLERGIES TO MEDICINES? (PLEASE CIRCLE!!)

PENICILLIN SULFA ASPIRIN CODEINE LOCAL ANESTHESIA TAPE ANTIBIOTICS

OTHER_____ NONE KNOWN

ALL PREVIOUS SURGERIES OR HOSPITALIZATIONS? _____

_____

_____

FAMILY HISTORY:

Mother Living_____Deceased_____Cause of death_____
Father Living_____Deceased_____Cause of death_____
Brother Living_____Deceased_____Cause of death_____
Sister Living_____Deceased_____Cause of death_____

Is there a family (blood relative) history of:

( ) Heart Disease Who:_____
( ) Arthritis ( )Hypertension ( ) Bunions ( ) Neurological Disorder
( ) Bleeding Disorder ( )Asthma ( ) Cancer ( ) Hammer-toes ( ) Flat Feet
( )Stroke ( ) Diabetes ( ) Gout ( )Phlebitis ( ) Circulation problems in legs or feet

PRINT PATIENT'S NAME: _____ DATE: _____

SOCIAL HISTORY:

Do you smoke: Yes _____ # of packs per day _____ No _____
Previously smoked? Yes _____ # of years _____ No _____

Do you drink alcohol or beer? Yes _____ No _____ Light __ Moderate __ Heavy __(2 or more per day)

Do you use recreational drugs? Yes _____ No _ ____

Employment: ( ) Sit ( ) Stand ( ) Stand and walk ( ) Retired

Does the employer require any particular type of shoes? Boots __ Heels __ Other __

REVIEW OF SYSTEMS:

Do you have any of the following? (PLEASE CIRCLE!!)

WEIGHT GAIN	WEAKNESS	FEVER	FATIGUE
CHEST PAIN	LEG EDEMA	PALPITATIONS	IRREGULAR HEARTBEAT
DIARRHEA	VOMITING	NAUSEA	REFLUX
CONSTIPATION	JOINT PAIN	JOINT SWELLING	JOINT STIFFNESS
MUSCLES ACHES	INCOORDINATION	GAIT ABNORMALITY	DIZZINESS
TINGLING/NUMBNESS	COUGH	SHORTNESS OF BREATH	ASTHMA
COPD			

HEIGHT: ____FT ____INCHES WEIGHT: _____SHOE SIZE:_____

PHARMACY NAME:_____ PHONE #_____

PRIMARY CARE PHYSICIAN:_____PHONE #_____

DATE OF LAST EXAM:_____IF FEMALE, COULD YOU BE PREGNANT?_____Weeks:_____

PATIENTS NAME:_____ DATE:_____

David H. Korfin DMP, PA

Fellow, American College of Foot and Ankle Surgeons
Diplomate, American Board of Foot and Ankle Surgery
1327 Lake Pointe Pkwy, Suite 510
Sugar Land Texas 77478
Office (281) 313-3338 / Fax (281) 313-3313

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are please to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, policy or your responsibility.

1. Co-pay and deductible payments are due at the time of service.
2. Payment can be made in the form of cash, check or credit card.
3. Insurance will be billed for services, if the insurance denies we will appeal. If appeal is denied, you will be responsible for the charges and may contact your insurance company.

_____ **Assignment of benefits**
I hereby authorize payment direct to Dr Korfin of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

_____ **Authorization to Release Information**
I authorize Dr. Korfin to release any and all information contained in my complete medical and billing record to:

1. My insurance company or its representatives
2. Other person or entities financially responsible for my care or treatment
3. The Medicare programs and their fiscal intermediaries, if applicable or
4. Federal or state agencies, required or permitted by laws or regulation