David H. Korfin DMP, PA

Fellow, American College of Foot and Ankle Surgeons
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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:_____ SS# _____

MARITAL STATUS: M S W D UNKNOWN PREFERRED LANGUAGE: _____

ETHNICITY_____ RACE _____

HOME PHONE #: _____ WORK PHONE #:_____x _____

CELL PHONE #: _____ E-MAIL ADDRESS: _____

EMPLOYMENT STATUS:_____ EMPLOYER: _____

WHO REFERRED YOU TO OUR OFFICE? : _____

SPOUSE - OR - PARENT

NAME: _____ GENDER: M F

DATE OF BIRTH:_____ SS# _____

IN CASE OF AN EMERGENCY: _____
NAME PHONE# RELATIONSHIP

INSURANCE INFORMATION

PLEASE CIRCLE ONE: HMO PPO POS MEDICARE (or HMO/PPO)
OTHER: _____

PATIENT INSURANCE: _____

INSURED NAME _____ INSURED D.O.B. _____

POLICY #: _____ GROUP#: _____

SECONDARY INSURANCE: _____

INSURED NAME _____ INSURED D.O.B. _____

POLICY #: _____ GROUP#: _____

MY FOOT PROBLEM IS _____ HOW LONG? _____

PRIOR OR SELF TREATMENT _____ HOW LONG? _____

NAME OF PREVIOUS DOCTOR: _____

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	
____ NEUROLOGIC DISORDER	____ SKIN PROBLEMS	____ STOMACH ULCER	____ REFLUX
____ THYROID	____ ELEVATED CHOLESTEROL		

ALL PREVIOUS SURGERIES OR HOSPITALIZATIONS? _____

_____

_____

DO YOU SMOKE?_____HOW MUCH?_____DO YOU DRINK ALCOHOL?_____HOW MUCH? _____

DO YOU TAKE ANY ILLICIT / STREET DRUGS? _____

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

PENICILLIN SULFA ASPIRIN CODEINE LOCAL ANESTHESIA TAPE ANTIBIOTICS

OTHER_____ NONE KNOWN

PRIMARY CARE PHYSICIAN_____PHONE #_____

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

REVIEW OF SYSTEMS:

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

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

I HEREBY GIVE DR. KORFIN PERMISSION TO EXAMINE AND TREAT MY FEET:

SIGNATURE:_____DATE: _____

PATIENT, PARENT OR GUARDIAN'S

PRINT PATIENT'S NAME: _____

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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:

Hospital of Surgical Excellence of Oak Bend
Elite Center for Minimally Invasive Surgery of Oak Bend
Compound RX
Premier Physical Therapy
National Interventional Radiology Partners
By my signature below, I hereby acknowledge that I have received notification of Dr. Korfin's ownership interests.

Patient Signature _____

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

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PHARMACY AND MEDICATIONS

Patients name:_____

Pharmacy name and number: _____

Height and weight: _____Shoe Size:_____

Are you currently taking any medications:

Name of Medication	Dosage	Prescribing Physician

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