HADFIELD
FOOT AND ANKLE
YOUR NEXT STEP FORWARD

Patient Name: _____

D.O.B.: _____

_____ **Married** _____**Single** _____ **Divorced** _____ **Widowed** **Sex:** _____**M**_____**F**

Address: _____

City: _____**State:** _____ **Zip Code:** _____

Home# _____ **Work#** _____

Cell# _____**Email:** _____

What is your preferred method of contact? _____ **Phone** _____**Text** _____ **Email** _____ **Mail**

Are you Employed? _____**Yes** _____**No** **Occupation:** _____

Emergency Contact: _____ **Phone:** _____

Relationship to Patient: _____

Primary Care Physician: _____

Who may we thank for referring you to us?_____

PCP Phone: _____**Last Date Seen:** _____

Primary Insurance Name: _____

Member ID: _____ **Group:** _____

Policy Holders Name: _____

Policy Holders D.O.B.: _____

Patient's relationship to Policy Holder: _____

Effective Date: _____**Termination Date:** _____

Hadfield Foot and Ankle
1505 Harroun Avenue, Suite H
McKinney, TX 75069
P: 469-247-1900 F: 888-365-3177

Patient's Name: _____ **D.O.B.** _____

Secondary Insurance Name:

_____

Member ID: _____ **Group:** _____

Policy Holders Name: _____

Policy Holders D.O.B.: _____

Patient's relationship to Policy Holder: _____

Effective Date: _____ **Termination Date:** _____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Robert Hadfield, DPM and Hadfield Foot and Ankle to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Robert Hadfield, DPM and Hadfield Foot and Ankle on any unpaid services filed on my behalf. **I understand that I am responsible for payment to Robert Hadfield, DPM and Hadfield Foot and Ankle for charges for the above patient regardless of my insurance coverage.** I also understand that Robert Hadfield, DPM and Hadfield Foot and Ankle are not responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Robert Hadfield, DPM permission to diagnose and administer treatment for my foot and/or ankle condition.

Patient's Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Date:** _____

HADFIELD
FOOT AND ANKLE
YOUR NEXT STEP FORWARD

Recording

Audio or video recording of any kind is prohibited without prior authorization from Dr. Hadfield. If authorization is requested and obtained, Hadfield Foot and Ankle, PLLC and Dr. Hadfield are not responsible for any misuse of such recordings including, but not limited to, distribution on the internet, unauthorized use by another third party or viewing by an unauthorized person. The person taking such a recording is expressly responsible for these risks and releases Dr. Hadfield and Hadfield Foot and Ankle, PLLC from any liability. The use of any such recording is not authorized for commercial or promotional use regardless of authorization to make a recording. Dr. Hadfield and Hadfield Foot and Ankle, PLLC are not responsible for any outcome of posting of such a recording on the internet.

Communication through Email and or Text

I understand that the information sent to me via email and/or via text message from persons at Hadfield Foot and Ankle, 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 non-secure communications via email and text message. I understand that Hadfield Foot and Ankle, and its staff, are not responsible for any unauthorized access of my protected health information communicated by the way of unencrypted email and text and that I bear the risk.

Signature: _____ Date: _____

Hadfield Foot and Ankle
1505 Harroun Ave. Suite H
McKinney, TX 75069

469-247-1900
www.Roberthadfield.com

Hadfield Foot and Ankle
1505 Harroun Avenue, Suite H
McKinney, TX 75069
P: 469-247-1900 F: 888-365-3177

Patient's Name: _____D.O.B._____

Chief complaint (What brings you to our office today?):

_____
_____
_____
_____

General Medical History (Please *circle* any conditions that you have/had:

Acid Reflux	Headaches	Rheumatic Fever
Alcohol / Drug Addiction	Heart Attacks	Rheumatoid Arthritis
Arrhythmia	Heart Disease	Seizures / Epilepsy
Arthritis	Heart Murmur	Sickle Cell
Asthma	Hepatitis	Stroke
Bleeding Disorder	High Blood Pressure	Hyper Thyroid Disease
Blood Clots	High Cholesterol	Hypo Thyroid Disease
Bowel Problems	HIV / AIDS	Tuberculosis
Broken Bones	Joint Pain / Back Pain	Ulcers/Acid Reflux
Cancer	Kidney Disease	Other: _____
Chicken Pox	Kidney Stones	_____
Collagen Vascular Disease	Liver Disease	
Depression / Anxiety	Lung Disease	
Diabetes	Lupus	
Drug Addiction	Osteoporosis	
Gall Bladder Disease	Pneumonia	
Glaucoma	Psoriasis	

Hadfield Foot and Ankle
1505 Harroun Avenue, Suite H
McKinney, TX 75069
P: 469-247-1900 F: 888-365-3177

Patient's Name: _____D.O.B._____

Smoking History:		Never smoked					
		Currently Smoke		Cigarettes/Day for		Years	
		Previously smoked		Cigarettes/Day for		Years	

Alcohol History:		Never use					
		Occasionally		drinks/day		drinks/week	
		Socially		drinks/day		drinks/week	

Do you currently use recreational drugs?:		Yes - What drugs?	
		No	

Family History: (List any family medical problems)	

Date	**Immunizations:**					
	Tetanus-Diphtheria Booster					
	Pneumoccocal Vaccine					
	Varicella Vaccine					
	Flu Shot					
	Hepatitis B Vaccine					
	Measles-Mumps-Rubella Vaccine					

Height: _____ Weight: _____Shoe Size: _____

Hadfield Foot and Ankle
1505 Harroun Avenue, Suite H
McKinney, TX 75069
P: 469-247-1900 F: 888-365-3177

Patient's Name: _____D.O.B._____

REVIEW OF SYSTEMS:

Constitutional:		Change in appetite		Weight loss
		Change in height		Weight gain
		Difficulty sleeping		Night sweats
		Fatigue		Other
		Fever		

Eyes:		Double vision		Spots before eyes
		Blurred vision		Vision Changes
		Glasses/contacts		Other

Ears, Nose, Throat:		Congestion		Ringing in ears
		Difficulty swallowing		Runny nose
		Earaches/Ear infections		Seasonal allergies
		Hearing problems		Sinus problems
		Mouth sores		Sore throat
		Neck stiffness/pain		Other
		Nose bleeds/bleeding gums		

Cardiovascular		Chest pain or pressure		Varicose veins
		Leg pain		Difficulty breathing when lying flat
		Leg swelling		Difficulty breathing with exertion
		Rapid or irregular heart rate		Other

Respiratory:		Chronic Cough		Wheezing
		Coughing up blood		Difficulty breathing when lying flat
		Painful breathing		Difficulty breathing with exertion
		Shortness of Breath		Other

Gastrointestinal:		Abdominal Pain		Hemorrhoids
		Acid reflux / heartburn		Incontinence
		Black tarry stools		Indigestion
		Bloody stools		Jaundice
		Constipation		Nausea/Vomiting
		Diarrhea		Other

Hadfield Foot and Ankle
1505 Harroun Avenue, Suite H
McKinney, TX 75069
P: 469-247-1900 F: 888-365-3177

Patient's Name: _____D.O.B._____

REVIEW OF SYSTEMS:

Genitourinary:		Blood in urine		Pain with urination
		Frequent urination		Discoloration of urine
		Urinary incontinence		Other
		Frequent urinary tract infections		
Musculoskeletal:		Back pain		Muscle weakness
		Joint pain		Joint swelling
		Joint stiffness		Redness or swelling of joints
		Muscle pain/cramps		Other
Skin:		Discoloration		Moles
		Difficulty healing		Open wounds/sores
		Dry skin		Rash
		Easy bruising		Other
		Itching		
Neurologic:		Burning		Headaches
		Tingling		Seizures
		Numbness		Tremors
		Dizziness		Other
Psychiatric:		Anxiety		
		Depression		
		Other		
Endocrine:		Abnormal hair growth		
		Abnormal thirst		
		Hair loss		
		Heat/cold intolerance		
		Other		

Hadfield Foot and Ankle
1505 Harroun Avenue, Suite H
McKinney, TX 75069
P: 469-247-1900 F: 888-365-3177

Patient's Name: _____D.O.B._____

Past Surgical History:

Date	Surgery

Medications: Please include any vitamins or non-prescription drugs:

Drug Name	Dose

Allergies:

Drug/Food/Other	Reaction

Are you allergic to Latex? ☐ YES ☐ NO

Pharmacy Name: _____

_____

Pharmacy Address: _____

_____

Pharmacy Phone # _____