Dr. Kennedy Legel, DPM, FACFAS
O 214-366-4600
F 214-366-4603
advancedFACS@gmail.com

Please complete all sections

PATIENT INFORMATION

Name:_____ Date of Birth:____/____/____
Last First Middle

Address:_____
Street City State Zip

Home phone:_____ Cell phone:_____

Email address:_____ Today's Date:_____

SSN:_____-_____-_____ Marital status: single married partnership divorced widowed

Spouse/Partner Name:_____ Spouse/Partner Employer:_____

PATIENT EMPLOYER INFORMATION

Employer name:_____

Address:_____
Street City State Zip

Work phone:_____ Contact person at work:_____

Is today's visit due to an injury at work? YES NO Personnel department notified? YES NO

INSURANCE INFORMATION

PRIMARY insurance company name: _____

ID/Member #:_____ Group name/number:_____

Effective date:_____ Expiration date: _____

Policy holder name:_____ Policy holder DOB:_____ Relationship:_____

SECONDARY insurance company name: _____

ID/Member #:_____ Group name/number:_____

Effective date:_____ Expiration date: _____

Policy holder name:_____ Policy holder DOB:_____ Relationship:_____

over please

POLICY HOLDER/RESPONSIBLE PARTY INFORMATION *(if different from above)*

Name:_____ Date of Birth:____/____/____
Last First Middle

Address:_____
Street City State Zip

Home phone:_____ Cell phone:_____

Email address:_____ SSN:_____-_____-_____

Patient relationship to policy holder:_____

MEDICAL PROVIDERS

Name of family physician:_____ City:_____ date last seen:_____

Name of former podiatrist:_____ City:_____ date last seen:_____

Pharmacy Name:_____ Phone:_____

Address:_____
Street City State Zip

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____
Last First Middle

Address:_____
Street City State Zip

Home phone:_____ Cell phone:_____ Work phone:_____

ADVANCED FOOT & ANKLE Care Specialists

The doctor-patient relationship is based on trust and open communication. In order to make a valid diagnosis and provide you with beneficial care, the information you provide must be complete and truthful.

PATIENT INFORMATION

Patient name:_____

Age _____ Race _____ Height _____ Weight _____

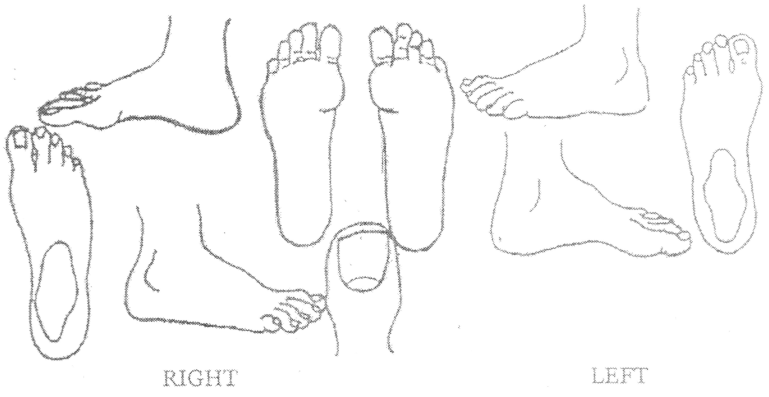
Gender _____ Shoe size/width _____ What type of shoes do you wear _____

CHIEF COMPLAINT/HISTORY of PRESENT ILLNESS

Current foot/ankle problem: _____

_____ Pain Scale (none) 1 2 3 4 5 6 7 8 9 10 (worst)

NATURE	LOCATION	COURSE
dull aching throbbing sharp stabbing burning tingling numbness _____	left right ankle foot 1st toe 2nd toe 3rd toe 4th toe 5th toe _____	intermittent constant random varied progressive sporadic



Duration (how long have you had the problem?)_____

Onset (how did it start?)_____

Aggravating Factors (what makes it worse?)_____

Treatment (what has been done?)_____

MEDICINES

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES

_____ _____

_____ _____

_____ _____

over please

SOCIAL HISTORY

Occupation_____ disabled retired Hobbies_____

How do you spend most of your time? Sitting standing walking heavy lifting

Do you **smoke**? YES NO **drink**? YES NO use illicit **drugs**? YES NO drink **caffeine**? YES NO
former chew tobacco social moderate heavy type_____ 1-2 3-4 5+

Have you received you **flu vaccine**? YES NO **pneumococcal vaccine**? YES NO **COVID vaccine** YES NO

FAMILY MEDICAL HISTORY

Father alive deceased PastMedHx_____
Mother alive deceased PMH_____
# of brothers _____ PMH_____
# of sisters _____ PMH_____

YOUR PAST MEDICAL HISTORY

Do you have or have you had any of the following conditions? (circle those that apply)

acne
anemia
anxiety
arthritis
artificial joint replacement
asthma
autoimmune dz (HIV/AIDS)
basal cell carcinoma
bleeding disorders
cancer _____
cataracts
Charcot foot
COPD/emphysema
CRPS/RSD
depression
diabetes type 1 type 2
epilepsy
fibromyalgia
GI bleeding
GI reflux/GERD
gout
heart attack
heart disease
hepatitis A B C D E
hernia
high blood pressure
high cholesterol
hyperthyroid
hypothyroid
kidney disease
liver disease
lower back pain/problems
malignant melanoma
melanoma
mitral valve prolapse
muscular dystrophy
pulmonary fibrosis
peripheral vascular disease
Raynaud's
rheumatoid arthritis
seizures
squamous cell carcinoma
stroke
warts
OTHER_____

Are you diabetic? YES NO

If yes, how long?_____ Controlled by? DIET PILLS INJECTIONS
If yes, what was your last glucose reading_____ taken when_____ A1c_____
do you walk barefoot YES NO
do you check your feet daily? YES NO
do you wear diabetic shoes? YES NO

PAST SURGICAL HISTORY & HOSPITALIZATIONS

_____ _____
_____ _____
_____ _____
_____ _____

Name of Family Physician:_____ Date last seen:_____
Name of Former Podiatrist:_____ Date last seen:_____

Whom may we thank for referring you to our office/How did you find us?_____

ADVANCED
FOOT & ANKLE
Care Specialists

VASCULAR/NEUROPATHY WORK SHEET

Do you experience pain at rest in your lower legs or feet?			YES	NO
Do you experience pain in your legs/feet when walking?			YES	NO
If yes, where does it hurt when walking?	THIGHS	KNEES	CALVES	FEET
Is the pain in your legs and/or feet relieved by rest?			YES	NO
How long does it take for the pain to subside after rest?			_____	
Are your toes or feet pale, discolored, or bluish?			YES	NO
Do cuts on your arms/hands and/or legs/feet take a long time to heal?			YES	NO
Have you noticed that less hair grows below your knees than above them?			YES	NO
Do you have or have you had ulcers on your feet?			YES	NO
Have you noticed that your feet feel cold even when the temperature is warm?			YES	NO
Do you suffer from numbness, tingling, burning, or pain in your legs and/or feet?			YES	NO
Do you have a high cholesterol level of other blood lipid problem, or do you take medication to lower cholesterol?			YES	NO
Do you have high blood pressure or take mediation for high blood pressure?			YES	NO
Do you have diabetes?			YES	NO
Have you ever smoked?			YES	NO
Have you previously had a stroke?			YES	NO
Do you have heart disease?			YES	NO

over please

CONSENT for RELEASE of INFORMATION & MEDICAL RECORDS

Date:_____

Patient's name:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____

I hereby give my permission for:_____
hospital/physician/insurance company

Address:_____
Street City State
Zip

Work phone:_____ Work fax:_____

To release or disclose to:_____
hospital/physician/insurance company

Address:_____
Street City State
Zip

Work phone:_____ Work fax:_____

The following information:_____

For the period beginning:_____ and ending:_____

This information will be used for:_____

I authorize this information to be released. This consent is subject to revocation at any time by me in writing.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

CONSENT for TREATMENT

I hereby give my permission for Kennedy Legel, DPM and his associates or assistants to examine and render treatment as may be necessary in the diagnosis and/or treatment of my foot and/or ankle condition(s) and release related information to my physician and/or emergency medical personnel as required by law.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

ASSIGNMENT of BENEFITS/FINANCIAL POLICY

As insurance coverage decreases and the patient's financial responsibility increases, we understand the need for clear and concise communication of our financial policies. Unfortunately, most insurance no longer covers services fully and many insurance plans chosen by our patients may require significant out-of-pocket expenses to be paid by the patient. With continuous changes in coverage, it is important to verify your benefits and be aware of all restrictions, limitations, and expenses of your particular plan.

It is your responsibility to verify that all requirements of your insurance plan are met. We will assist you with pre-certification for procedures ordered by our office, but it is ultimately your responsibility to verify whether any care rendered is covered by your insurance plan. We are not responsible for the expense of treatment which is not paid by your insurance. Although you have requested us to bill your insurance company in the case of surgery, you clearly understand that it is still *your responsibility to make sure the bill is paid within a reasonable time frame*.

I hereby authorize my insurance company to pay directly to Kennedy Legel, DPM the benefits and amounts due and otherwise payable to me for medical supplies and services, as described on the customary charges for those supplies and services. I acknowledge and understand that I am *responsible for all of the charges for all services* rendered to me or any member of my immediate family. If, for any reason, any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt and timely payment of the balance. I further acknowledge that I have read and understand the financial policy. I accept responsibility for payment of any balance owed on my account. I understand I am financially responsible for all charges whether or not paid by insurance. In the unforeseen event that a refund or overpayment is due to you, we will happy to issue you a refund upon request.

I understand that I will be charged a non-refundable fee of $25 if I miss my appointment or cancel my appointment with less than 24 hours notice. I also understand that I may be charged a non-refundable fee of $125.00 if I cancel a surgical procedure that has been scheduled with a hospital or surgery center. This fee will need to be paid in advance or at the time of my next appointment. I understand that the purpose of this policy is to allow any available appointment or surgery time to be used by patients that need to be seen.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

over please

MEDICARE *(if applicable)*

I hereby authorize my insurance company to pay directly to Kennedy Legel, DPM the benefits and amounts due and otherwise payable to me for their services, as described on the attached forms, but not to exceed the customary charges for those services. I understand that I am *financially responsible for all remaining charges* incurred whether or not covered by said insurance.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

AUTHORIZATION to RELEASE INFORMATION

I _____ hereby authorize Kennedy Legel, DPM to release any information regarding medical treatment for the purpose of validating and determining benefits payable in connection with any claims. I may revoke consent for the above item at any time in writing.

I also understand that there is a $25 non-refundable fee for any requested medical records or the completion of any forms, including FMLA, and others.

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____

NOTICE of PRIVACY PRACTICES

Kennedy Legel, DPM and associates are committed to protecting the privacy and security of individual identifiable health information and other protected health information of a confidential nature for this medical practice as set forth in the Health Insurance Portability and Accountability Act (HIPPA). I hereby acknowledge that I have read this "notice of privacy practices" link on the website (www.afcdallas.com) or have had the opportunity to do so if I so chose.

Due to the ever-changing world of healthcare and technology, we have the ability to communicate with our patients via email and text messaging. When you provide us this information, it will only be used to communicate with you. We do not share the names, email, and/or telephone numbers of our patients with any other company or patient. To provide you with the best possible care, we will communicate with you through a variety of technology services. You are currently set to receive text messages for appointment reminders and emails about your health care treatment and promotions. If you wish to change your preferences or if you wish to decline receiving all communication from us, please inform us and we will adjust your preferences. The mobile device associated with your patient files is 214-763-2900. We look forward to providing better and more convenient communications with you. Our goal is to provide you with relevant and useful information about your health care and the products and services we offer for improving your health. Thank you!

Signature of patient:_____ Date:_____

Signature of parent (If minor):_____ Date:_____