Graff
FOOT • ANKLE
WOUND CARE

Main Office
2633 Dallas Parkway
Suite 100
Plano, TX 75093

Satellite Office
2100 Hedgecoxe Rd
Suite 100
Plano, TX 75025

972-403-7733 phone
972-403-7744 fax
DrGraff.com

PATIENT INFORMATION

Patient name: _____
First Middle Last

Social Security #: _____ Sex: ☐M ☐F Date of birth_____/_____/_____ Age _____

Home phone: ( ) _____ Cell phone: ( ) _____ Work phone: ( ) _____

Address: _____ E-mail _____
Street City State Zip

Job Title _____

Weight: _____ Shoe size: _____ Height _____

Are you of Hispanic or Latino origin or descent? ☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino

What is your race? Please mark one or more. ☐ White ☐ Black or African-American ☐ Asian

☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native

What is your Primary Language? _____

Primary doctor: _____ Phone #: _____ Pharmacy: _____ Phone #: _____

Are you currently in a skilled nursing facility, rehab, or long term care facility? ☐ Yes ☐ No

Name of facility _____ Address of facility _____

Do home health nurses visit you? ☐ Yes ☐ No Name of the home health company? _____

How did you hear about Dr. Graff? _____

SPOUSE/PARENT/GUARANTOR INFORMATION

Name: _____
First Middle Last

Home phone: ( ) _____ Cell phone: ( ) _____ Work phone: ( ) _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ Policy#: _____ Group #: _____

Policy holder name: _____ DOB: _____ Social Security #: _____

SECONDARY INSURANCE: _____ Policy#: _____ Group #: _____

Policy holder name: _____ DOB: _____ Social Security #: _____

EMERGENCY CONTACT

Name: _____ Relationship _____ Home: _____ Cell: _____

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CONSENT FOR TREATMENT

I give my consent to be treated by Jeremiah Graff, DPM, CWS at **Texas Center for Foot & Ankle Surgery/Texas Center for Advanced Wound Care** or my residing facility. I understand that this is a general consent, and that if I am to undergo surgery I will sign the appropriate informed consent form prior to receiving that service.

CONSENT FOR PHOTOGRAPHS/VIDEO/MULTIMEDIA

I give permission to **Texas Center for Foot & Ankle Surgery/Texas Center for Advanced Wound Care** to take pictures/video/multimedia for reference and charting purposes.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize **Texas Center for Foot & Ankle Surgery/Texas Center for Advanced Wound Care** to release medical, psychiatric and substance abuse information contained in my/the patient's records to insurance carrier(s), physicians or other healthcare practitioners. Unless noted below, medical records released may include diagnostic and therapeutic information (including test for HIV antibody/substance abuse).

Withhold from release: (please specify if any)_____

Information is disclosed from records whose confidentiality is protected by Federal and State law. Federal regulations or State law prohibit making any further disclosure of HIV antibody/substance abuse without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal/State law.

Please list the names of any other people your medical records and information may be provided to (i.e. spouse, parent, caregiver, etc):

Name(s): _____ Relationship: _____ Phone:_____

PAYMENT POLICY

~By signing below I am providing "Assignment of Benefits" permission for Dr. Graff to file claims to my insurance carrier on my behalf.

~All co-payments, co-insurance and deductibles must be paid at the time of service as required by the terms of your health insurance provider. *Please understand that failure on our part to collect these payments can be considered insurance fraud.* For your convenience we accept: MasterCard, Visa, Discover & AMEX.

~Please be aware that some of the services you receive may not be deemed medically necessary by your insurance carrier, therefore, you will be responsible for payment of all services not covered.

~There is a $25 fee for paperwork that needs to be completed such as, but not limited to, disability paperwork, copies of x-rays and medical records.

By signing below, I acknowledge that I understand the information on this document. I also permit a copy of this to be used in place of the original.

_____ _____

Patient/Guarantor Signature Date

_____

Patients Printed Name

6105 Windcom Court Suite 100, Plano, TX 75093 Phone 972.403.7733 Fax 972.403.7744
E-Mail texasfootsurgery@verizon.net DrGraff.com

What type of problem are you having with your feet/legs?

When did your symptoms begin? Have you seen another doctor for this problem?

Allergies to Medications

Please list:

Current Medications

Please list:

Flu Vaccinations

❑ Yes, I have had the vaccine this year ❑ I have been vaccinated in the past ❑ No, I do not get the flu vaccine

Past Medical History

❑Anemia
❑Arthritis
❑Bleeding Disorder
❑Cancer
❑Diabetes ❑Type 1 ❑Type 2
❑Dialysis
❑Gout
❑Heart Problems (Type_____)
❑Heart Valve Replacement
❑Hepatitis _____
❑High Blood Pressure
❑High Cholesterol
❑HIV
❑Joint Replacement
❑Kidney Disorders
❑Lung Disease
❑Multiple Sclerosis
❑Murmur
❑Osteoporosis
❑Pacemaker
❑Poor Circulation
❑Stroke
❑Thyroid Condition
❑Please list any other history:

Past Surgical History

Surgical Procedure Date

Social History

Do you exercise? ❑ Y ❑ N
Do you drink alcohol? ❑ Y ❑ N
Do you smoke?
❑Current Smoker ❑Former Smoker ❑Never
History of depression? ❑ Y ❑ N

Review of Systems

Please check current symptoms even if controlled with medication.

☑	***GENERAL***	☑	***CARDIOVASULAR***	☑	***MUSCULOSKELETAL***	☑	***FAMILY HISTORY***
☐	Nausea/Vomiting	☐	High Blood Pressure	☐	Foot Pain	☐	Cancer
☐	Fever	☐	Murmur	☐	Ankle Pain	☐	Diabetes
☐	Chills	☐	Pacemaker	☐	Toe Pain	☐	High Blood Pressure
☐	Dizziness	☐	Mitralvalve Prolapse	☐	Difficulty Walking	☐	Stroke
☐	Unusual Fatigue	☐	A Fib	☐	Weakness in Legs	☐	Kidney Disease
☑	***HEAD, EYES, THROAT***	☐	Swelling in Legs	☐	Foot Deformity		
☐	Chronic Cough	☑	***NEUROLOGICAL***	☐	Heel Pain	☑	***OTHER***
☐	Chronic Headaches	☐	Stroke	☐	Leg Cramping	☐	
☐	Blurred Vision	☐	Numbness in Feet	☐	Swelling in Foot or Ankle	☐	
☐	Trouble Swallowing	☐	Tingling in Feet	☐	Leg Pain when Walking	☐	
☐	Blurred/Double Vision	☐	Burning in Feet	☐	Leg Pain at Rest	☐	
☐	Poor Vision	☑	***SKIN***	☑	***GASTROENTEROLOGY***	☐	
☑	***RESPIRATORY***	☐	Wound/Sores	☐	Blood in Urine or Stool	☐	
☐	Shortness of Breath	☐	Rash	☐	Frequent Urination	☐	
☐	Difficulty Breathing	☐	Skin Cancer	☐	Constipation	☐	
☐	Asthma	☐	Wart			☐	

Date: **Patient Name:** **Date of Birth:**