Drs. James Jacobs & Nicolas Manriquez
1331 W. Grand Parkway N., Suite 140, Katy, TX 77493

Patient Name ____________________________________ **Date:** _________________________
Last First Middle

PERSONAL INFORMATION

Address________________________________
City, State, Zip___________________________
Cell No.(_____) _________________________
Home No.(_____)__________________________
Work No.(_____)__________________________
Call me at ☐ Home ☐ Cell ☐ Work
DOB_______________ Sex ☐ M ☐ F Age_____
SSN__________________________________
Marital Status ___________________________
E-mail ________________________________
May we send you health info ☐ Yes ☐ No
Employer ______________________________
Occupation _____________________________
Family Physician _________________________
Phone # _______________________________
Date Last Seen __________________________

EMERGENCY CONTACT

Name ________________________________
Relationship ____________________________
Home Phone (_____) ____________________
Cell Phone (_____) ______________________

INSURANCE

Primary Insured _________________________
Relationship to patient ___________________
SSN ____________________DOB __________
Employer ______________________________
Phone # (_____) _________________________
Who receives bills? ☐ Same as patient **If not:**
Name:_____________________________
Address:____________________________
City, State Zip_________________________
Phone #:____________________________
SSN:_______________________________

WHO MAY WE THANK FOR YOUR REFERRAL

☐ Doctor ______________________________
☐ Cinco Ranch Golf Club
☐ Friend/Family_________________________
☐ Insurance

Publications, please check one below
☐ Living ☐ Absolutely Katy ☐ Katy Parent
☐ Lifestyles & Homes ☐ La Subasta ☐ Katy Sports

WHO MAY WE THANK FOR YOUR REFERRAL

☐ Internet
☐ Location
☐ ValPak
☐ Welcome Home ☐ Other ___________________

Phone Book, please check one below
☐ Consolidated ☐ AT&T ☐ Yellow Book
☐ Cinco-Ranch

TREATMENT CONSENT

Please initial all areas with **, sign bottom of page.

**__________ I verify that all of the information provided is correct.

**__________I hereby consent and give permission to Dr. Jacobs/Manriquez (and his assistants') to administer and perform recommended procedures upon me as the doctor deems necessary, after thorough explanation and understanding by me.

**_________Any pictures, memoranda, or other medical information taken during my visit may be used by Dr. Jacobs/Manriquez for medical illustrations and/or educational purposes.

FINANCIAL POLICY & HIPAA

**__________Payment is requested at the time of services for all office charges. Our office will file insurance claims for all participating insurance plans. If an outpatient procedure is recommended, all financial arrangements will be completed prior to scheduling any procedures. We will verify your coverage, however the information obtained in not a guarantee of benefits/payments. Any claims not paid by my insurance carrier within 45 days will become my responsibility. MY SIGNATURE VERIFIES THAT IF MY INSURANCE INFO IS NOT ACCURATE AND UP-TO-DATE THEN I WILL BE RESPONSBLE FOR ALL BALANCES. I have read and understood the above policies and acknowledge that I am responsible for payment of this account.

**_________I, the undersigned certify that I (or my dependent) have insurance coverage, as listed above, and assign directly to Your Total Foot Care Specialist, PA (YTFCS) all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or nor paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**__________I acknowledge that I have received YTFCS Notice of Privacy Practices. I acknowledge that all communications to me by our office will be handled by telephone, mail, or e-mail.

____
Signature of Patient or Authorized Representative Printed Name Date

Your Total Foot Care SPECIALISTS
www.KatyFootCare.com

Drs. James Jacobs & Nicolas Manriquez
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Patient Name ______________________________________ **Date:** __________________________
Last First Middle

Pharmacy Name ________________________ Phone # ________________________

FOOT HEALTH ASSESSMENT

Shoe Size__________ Height __________Weight _____

YES	NO	
☐	☐	My feet are sore and/or achy on a regular basis
☐	☐	I experience heel and/or arch pain
☐	☐	Standing, walking, or running causes pain (ankles, knees, hip, or back)
☐	☐	I have visible foot problems (calluses, corns, bunions, etc.)
☐	☐	My feet roll in and/or roll out
☐	☐	My shoes wear out quickly or unevenly
☐	☐	I play sports regularly (tennis, golf, basketball, etc.)

Describe your foot problem (s)

____

____

Length of symptoms?_____**(Check how long)** ☐Days ☐Weeks ☐Months ☐Years

MEDICAL HISTORY Check all that apply - Past & Present

☐AIDS/HIV
☐Allergies to Anesthetics
☐Allergies to medicine or drugs
☐Alzheimer's
☐Arthritis
☐Artificial Heart Valve or Joint
☐Back Problems
☐Bleeding Disorders
☐Cancer
☐Chest Pain
☐Circulatory Problems
☐Diabetes – family or personal
☐Drinking
☐Epilepsy
☐Gout
☐Heart Disease

☐Hemophilia
☐Hepatitis
☐High Blood Pressure
☐Liver Disease
☐Neuropathy
☐Phlebitis
☐Pregnant/Nursing
☐**Smoking – Packs / day? _____**
☐Stomach/GI Ulcers
Other ___________________

ALLERGIES

☐No known allergies
☐Adhesive tape
☐Local Anesthetics
☐Aspirin
☐Penicillin
☐Iodine / Shellfish
☐Codeine
☐Demerol
☐Food Allergies
Other _______________

____

FAMILY HISTORY

Mother ☐Living ☐Deceased
Cause of death_______________
Father ☐Living ☐Deceased
Cause of death_______________
Sister ☐Living ☐Deceased
Cause of death_______________
Brother ☐Living ☐Deceased
Cause of death_______________

MEDICATIONS

☐No medications - List all prescriptions, over-the-counter medications, vitamins, and dosages

____

____

Previous surgeries____

____

Your Total Foot Care
SPECIALIST
www.KatyFootCare.com