# The Foot Institute

## Efren Buff De La Rosa, DPM, FACFAS

### Diplomate, American Board of Podiatric Surgery

### Board Certified

Patient Intake Form

**Date: _____**

## Patient:

Last: _____

First: _____

Address: _____

City: _____

State/Zip Code: _____

Home Phone: _____

Work Phone: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Occupation: _____

Referred by: _____

Emergency Contact: _____

Phone: _____

EMAIL ADDRESS:_____

## Responsibility Party:

**(Who is financially responsible for the bill?) **MUST BE FILLED OUT COMPLETELY****

Last: _____

First: _____

Address: _____

City: _____

State/Zip Code: _____

Home Phone: _____

Work Phone: _____

Relationship to Patient: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Occupation: _____

---

## Primary Insurance

Name of Insurance: _____

## Secondary Insurance

Name of Insurance: _____

PAYMENT POLICY:

All services rendered are the financial responsibility of the patient or the patient's parent or guardian. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement for private insurance carriers.

AUTHORIZATION OF PAYMENT:

I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered.

**Signed: _____**

# Efren De La Rosa, DPM
# 114 W. Castellano
# El Paso, TX 79912

Patient Medical History

## General Data

Patient Name: _____ Age: _____

Sex: ___F ___M Are you pregnant? _____ If so, how many months? ____

**Chief Complaint:**
_____
_____

**When or How Long: _____** **Previous Treatment: _____**

**Type of Pain: _____** **Job Related? _____**

**Allergies : _____**

**Allergies to Medications: _____**

## Medical History

Last Physical Exam: _____

General Doctor: _____

Hospitalizations / Surgeries:
_____
_____
_____

Recent Weight Loss: _____

Bleeding Tendencies: _____

Scarring Tendencies: _____

Stomach Ulcers: _____

Heart Problems: _____

Arthritis: _____

High Blood Pressure: _____

Kidney/Liver Problems: _____

Diabetes: _____

Blood Clot in Legs: _____

Joint Implants: _____

HIV Positive: _____

Smoke: _____ How Much: _____

Alcohol: _____

Past or Present Use of Illegal Drugs: _____

Who may we thank for referring you to our office or how did you hear about us?

_____

_____

Other Medical Problems: _____

Family History of Medical Problems:
_____**Information Taken By:**
_____Date: _____
Received Doctor's Initials: _____

# MEDICATION FLOW SHEET

| Name: | | Allergies: |
|---|---|---|
| Date | Medication | Refills: Date/Initials |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# AGREEMENT/CONDITIONS OF TREATMENT

This is an agreement between Dr. Efren De La Rosa and myself, summarizing our discussion and understanding of the conditions under which I consent to treatment of my foot/ankle problems.

- I understand that my physician, Dr. Efren De La Rosa, will use his best skills and judgment to accomplish the desired result, but that Dr. Efren De La Rosa cannot and does not warrant or guarantee such result; also that his forecast of the length of time involved in therapy and/or recovery from surgery, the manner of recovery and the possible complications of untoward results is based upon the usual and average response in cases similar to mine, but that is not a promise, since my result response may be different from the usual.

- On my part I promise full cooperation with Dr. Efren De La Rosa and his staff in my treatment, whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions, or the instructions of his staff, concerning my care and treatment, including any necessary physical therapy, then the outcome of my care and treatment could be put into jeopardy and a bad result may occur.

Patient
/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

# THE FOOT INSTITUTE
# 114. W. Castellano Drive
# El Paso, Texas 79912
# (915) 532-3721

## Acknowledgement of Receipt of Notice or Privacy Practices

## Recibo de Notificación de Prácticas de Confidencialidad

My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

Certifico que hé rechibido una copia de la Notificación de Prácticas de Confidecialidad.

_____ _____

Signature of Patient or Legal Representative — Date / Fecha
Firma de Paciente o Representante Legal

If signed by legal representative, relationship to patient is: _____
(Si esta firmado por respresentante legal, relacion al palciente es:)

____Patient declined to sign / Patiente declinó firmar

Reason / Razon: _____

_____

_____

**THE FOOT INSTITUTE**

**114. W. Castellano Drive**

**El Paso, Texas 79912**

**(915) 532-3721**

# Courtesy Billing and Verifying:

As per our billing and verifying department we would like to inform you (our patient) that in order for our office to provide our patients excellent customer service, we do verify all insurance benefits prior to the patients visit. Do keep in mind that this is a courtesy to our patients and all verifying and billing is not a guaranteed of payment for the services provided.

It is important for our patients to understand that you are still financially responsible for the account and any balances not paid by your insurance carrier (s).

I agree to pay any unpaid balances that my insurance carrier (s) does not pay for the services provided to me by Dr. Efren De La Rosa, DPM.

_____ _____

Patient Signature Date