

Texas Center
for Foot and Ankle Surgery



Texas Center
for Advanced Wound Care

Jeremiah Graff, DPM

6105 Windcom Ct. #100
Plano, TX 75093
972-403-7733 phone
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2100 Hedgcoxe Road #100
Plano, TX 75025
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2002 Oxford Ave
Lubbock, TX 79410
972-403-7733 phone
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texasfootsurgery.com

texasfootsurgery@verizon.net

PATIENT INFORMATION

Patient name: _____
First Middle Last

Social Security #: _____ Sex: M F Date of birth ____/____/____ Age ____

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

Email _____

Address: _____
Street City State Zip

Employer Name _____ Employer Phone _____

Primary doctor: _____ phone #: _____ Pharmacy: _____ phone #: _____

How did you hear about Dr. Graff? _____
Height _____ Weight: _____ Shoe size: _____

SPOUSE/PARENT/GUARANTOR INFORMATION

Name: _____
First Middle Last

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

Address: _____

Employer Name _____ Employer 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: _____

Address: _____

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Jeremiah Graff, DPM

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/we 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: _____

Relationship: _____ Phone: _____

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

E-Mail texasfootsurgery@verizon.net

Phone 972.403.7733 Fax 972.403.7744

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Medical History

Name: M F Date of Birth:

What brought you to see the doctor?

When did your symptoms begin?

What treatments have you tried?

What other foot/ankle problems have you had?

Females: Are you pregnant? Y N

Allergies to Medications

Please list:

Current Medications

Please list:

Past Medical History

PLEASE CHECK WHAT YOU HAVE BEEN TREATED FOR...

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Arthritis (Type _____) | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Bleeding Disorders _____ | <input type="checkbox"/> Kidney Disorders |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Lung Disease (Type _____) |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | <input type="checkbox"/> Murmur |
| Insulin Dependent <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Problems (Type _____) | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Please list any others: |

Social History

Do you exercise? Y N Type? _____ How often? _____

Do you smoke? Y N If yes, how much? Do you drink alcohol? Y N If yes, how much?

Past Surgical History

Procedure	Date	Surgeon	Complications

Review of Systems					
GENERAL	Current	Previously	DIGESTIVE	Current	Previously
Diabetes			Heartburn		
Rheumatoid Arthritis			Vomiting		
Stroke			Constipation		
Recent Chemotherapy			Diarrhea		
Recent Radiation			Blood with Stools		
HEAD, EYES, EARS			CARDIOVASCULAR		
Dizziness			High Blood Pressure		
Change in Hearing			Use Oxygen at Home		
Sore Throat			Pacemaker		
Trouble Swallowing			Swelling in Arms/Legs		
Blurred/Double Vision			Bleeding Disorders		
Poor Vision			MUSCLE, BONES, JOINTS		
RESPIRATORY			Leg Pain – at Rest		
Frequent Colds			Leg Pain – Walking		
Difficulty Breathing			Back Pain		
Cough			Joint Aching/Pain		
Asthma/Hay Fever			Swelling of Joints		
Emphysema			Difficulty with Joint Motion		
Other			Difficulty Walking		
NEUROLOGICAL			SKIN		
Change in Memory			Rash		
Trouble with Balance			New Growths/Lumps		
Change in Sensation			Color Change in Mole or Wart		
Stroke			Skin Cancer		
Numbness in Feet			Ulcers/Sores		
Tingling/Burning in Feet					
BLADDER/KIDNEY			FAMILY HISTORY	Paternal	Maternal
Frequent Urination			Diabetes		
Burning on Urination			High Blood Pressure		
Blood in Urine			Heart Disease		
Difficulty with Urination			Stroke		
Other			Kidney Disease		

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