PMPT

Podiatric Medical Partners of Texas

Mark A. Barinque, DPM,PA

Patient Information:

Last Name_____**Firstname**_____M.I._____

Address_____**City**_____**ST**_____**Zip code**_____

Birthdate _____**SSN**_____-___-_____Sex:__M __F **Marital status**(S,D,M,W)_____

Home phone _____**Cell phone** _____**Work phone**_____

Ht_____Wt_____Shoe Sz_____**Primary Care Physician** _____Last Date Seen_____

Patient's Occupation _____Employer's Name_____

If Student: ___Full ___PT **Email Address**_____

Race: (You may check more than one)

___Asian___ African American ___White ___Hispanic ___Other

Ethnicity: ___Hispanic/Latin ___Non-Hispanic **Language**: ___English ____Spanish

Pharmacy _____Address _____Phone #_____

Name of Insured (Guarantor)_____SSN_____DOB_____

Emergency Contact_____Phone#_____Relatonship_____

Referred by _____Physician_____Family/Friend

Disclosure Regarding Solicitation of Patients

(as required by section 102 of the Texas Occupational Code)

Texas law requires that at the time of initial contact and at the time of referral, Texas Physicians disclose to patients (i) any affiliation the physician has with a person or healthcare facility for whom the patient is secured or solicited, and (ii) that the physician may receive, directly or indirectly, re-numeration for securing or soliciting the patients. This disclosure is intended to help you make a fully informed decision about your healthcare. Mark A. Barinque, DPM has direct or indirect ownership with Lubbock Heart and Surgical Hospital and may receive re-numeration from the listed healthcare facility. Please let our staff know if you have any questions. Thank you.

Reason for Visit

Patient Name: _____ **Date:** _____

What type of foot problem are you having today?

When did the problem start?

Have you had this problem before? _____Yes_____No

Did you injure or traumatize your foot? _____Yes_____No. Please explain the event.

Has the problem improved, unchanged or worsened? (Circle one)
What makes the problem worse?

How have you treated your condition?

Have you been treated by another physician for this problem? _____Yes_____No. Please List.

List any Medications taken for this problem

Patient Health History

Name: _____ **Date:**_____ **DOB:** _____

Chief Complaint: What is the reason for your visit today? (Please describe problem in detail including history of present illness):

Past Medical History: Please check all that apply to you:

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Chest Pain
- ❑ Congestive Heart Failure
- ❑ Depression
- ❑ Diabetes (Type I or II)
- ❑ Chronic Fatigue syndrome
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve
- ❑ Multiple Sclerosis
- ❑ Neuropathy
- ❑ Poor circulation
- ❑ Psychiatric disease
- ❑ Fibromyalgia
- ❑ Rheumatoid Arthritis
- ❑ Raynaud's
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid
- ❑ Ulcers (GI)
- ❑ Lupus
- ❑ Other

Previous Surgeries: Please list past surgeries with approximate date:

Medications: Please list any medications you are taking with dose and frequency:
Drug Dose/Frequency

Allergies (Drug, Food, Latex, etc..) : Please list any allergies that you have and type of reaction

_____

_____

_____

Social History:
Do you drink alcohol? ❑Yes ❑No If yes, how much/week?

Do you smoke? ❑Yes ❑No If yes, how many cigarettes/day?

Do you consume caffeine? ❑Yes ❑No If yes, how many cups/week?

Do you use recreation drugs? ❑Yes ❑NoIf yes, what type and frequency?

Are you on a special diet? ❑Yes ❑NoIf yes, please describe?

Family History: Do you know of any blood relative who has or had:

- ❑ Asthma
- ❑ Aneurysm
- ❑ Brain Tumor
- ❑ Cancer
- ❑ Diabetes
- ❑ High blood pressure
- ❑ Heart Problems
- ❑ Kidney disease
- ❑ Lung Disease
- ❑ Migraine
- ❑ Multiple Sclerosis
- ❑ Thyroid
- ❑ None

Comments:

General Health
- ❑ Good general health
- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Fever/chills

Allergy
- ❑ Drug allergies
- ❑ Food allergies
- ❑ Hay fever
- ❑ Other:
- ❑ None

Ears, Nose, Mouth, Throat
- ❑ Difficulty swallowing
- ❑ Earaches
- ❑ Loss of hearing/deafness
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Ringing in ears
- ❑ Sinus infection
- ❑ Sores in mouth
- ❑ None
- ❑ Other:

Eyes
- ❑ Blind spots
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Glaucoma
- ❑ Pain
- ❑ Other:
- ❑ None

Gastrointestinal
- ❑ Blood in stool
- ❑ Nausea
- ❑ Painful bowel movements
- ❑ Persistent diarrhea
- ❑ Stomach or abdominal pain
- ❑ Ulcer
- ❑ Vomiting
- ❑ Other:
- ❑ None

Neurological
- ❑ Balance trouble
- ❑ Mini stroke
- ❑ Stroke
- ❑ Tremors
- ❑ Weakness
- ❑ Both
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Neuropathy
- ❑ Black outs/loss of consciousness
- ❑ Memory loss
- ❑ Mental Confusion
- ❑ Migraines

Genitourinary
- ❑ Blood in urine
- ❑ Female: irregular periods
- ❑ Female: #pregnancies_____ #miscarriages_____
- ❑ Kidney stones
- ❑ Painful or burning urination
- ❑ Sexual difficulty
- ❑ Sexually transmitted disease
- ❑ Urgency with urination
- ❑ Other:
- ❑ None

Heart and Lungs
- ❑ Pain in chest
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat
- ❑ Other:
- ❑ None

Muscles/Joints/Bones
- ❑ Back pain
- ❑ Difficulty walking
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle pain or tenderness
- ❑ Neck pain
- ❑ None

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder
- ❑ Other: _____
- ❑ None

Pulmonary
- ❑ Asthma
- ❑ Blood in cough
- ❑ Cancer
- ❑ Chronic or frequent cough
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Other: _____
- ❑ None

Skin
- ❑ Rash or itching
- ❑ Sun sensitivity
- ❑ Color changes
- ❑ Other: _____
- ❑ None

_____

Patient Name

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I read (or had the opportunity to read) and understand the notice.

_____ _____

(Patient Signature /Parent or Guardian signature (Date)

If Parent or Guardian Signature, please describe relationship to the patient _____

Please indicate any person(s) authorized to discuss your Personal History Information (PHI) with our office or those who you authorize to receive information regarding your PHI. Include the person's name & relationship to you. Include a start and end if applicable to set restrictions to any individual(s)

Name	Relationship
1_____	_____
2_____	_____
3_____	_____

PAYMENT OF BENEFITS AND TERMS

I understand that Dr. Mark A. Barinque (Podiatric Medical Partners of Texas (PMPT) will bill my insurance company and I have provided adequate information. I authorize the release of medical information necessary to process the claim for medical benefits by my insurance company directly to Dr. Mark A. Barinque (PMPT). I acknowledge that I am responsible for all charges incurred and understand insurance co-payments are due at the time of service. If the co-pay cannot be paid at the time of service we may need to reschedule your appointment. I understand and agree to the above terms and information of Dr. Mark A. Barinque (PMPT)

Patient/Parent or Guardian Signature _____Date_____

Witness Signature_____Date_____

(Representative of Dr. Mark A. Barinque)