Scott Nelson DPM
3930 Naaman School Road, Suite C
Garland, TX 75040
Phone 972-414-9800 Fax 972-414-9802

Today's Date:_______________

Patient's First Name:______________________ Middle Initial:_______ Last Name:_____________________________

If Patient is a Minor, Please Provide Name of Parent: ____

Address: _________________________________ Apt #:_____ City:__________________ State: ____ Zip:_________

Email Address: ____

Male or Female Social Security Number: ______- _____ - ______ Date of Birth: ____/_____/______

Home Phone: _____________________ Work Phone: _________________________ Cell Phone:_________________

Preferred Phone Number: ________________________ Can we leave a message? ___________________________

Employer: ____

Spouse's First Name: ______________________ Middle Initial: _______ Last Name:_____________________________

Emergency Contact: _______________________ Relationship: ______________Ph#:_______________________

Primary Care Physician: ___________________________________ Phone number: _________________________

Date last seen by Primary Care Physician: ____/_____/______

How did you hear about us? ☐ Patient ☐ Physician ☐ Internet______________ ☐ Other___________________

Insurance Co-Pay for Specialist Physician: $___________

Person Responsible for Payment: __________________________ Relationship to Patient: _________________

Address: ________________________________ Apt #:_____ City:__________________ State: ____ Zip:_________

Home Phone: _____________________ Work Phone: _____________________ Cell Phone: _________________

PHARMACY INFORMATION:

Pharmacy Name: _____________________________________ Pharmacy Phone#: ____________________________

Pharmacy Address: ____

____

HEALTH HISTORY

Fill out this information to the best of your ability. Providing incorrect information can be dangerous to your health. Please inform our office when there are any changes in the medical information you provide.

Name:_____________________________ DOB:____________ Today's Date:_____________
Height:______________ Weight:____________ Sports you participate in:___________________
Please describe your current foot problem:____
Was the problem a result of an accident or event (explain)?________________________________

PAST MEDICAL HISTORY - Please describe any conditions you have been diagnosed with:

Cancer: ______Type: ________________
Cardiac (Heart): ____________________
Diabetes: _______ Type: _____________
Ear/Nose/Throat:____________________
Eye: _______________________________
Gastrointestinal: ____________________
Hematological: _____________________
HIV: ______________________________

Hypertension: ________________________
Musculoskeletal: ______________________
Neurologic: ___________________________
Psychiatric: ___________________________
Pulmonary: ___________________________
Skin and Subcutaneous Tissue: __________
Vascular: _____________________________

Please describe any previous **surgeries**:

Please list your current **medications**:

Medication	Dosage	Reason	Prescribing Physician

Please list important **family disease history**:

Father ______________________
Mother _____________________
Sibling _____________________

Please list quantity/frequency of the following **social** activities:

Smoking______________________
Alcohol_______________________

Please list any **drug allergies** and describe your **reaction**:

REVIEW OF SYSTEMS - Please check any symptoms you are currently experiencing:

Head & Eyes:
Dizziness ____ Headaches _____

Ear/Nose/Throat:
Hearing loss ____

Respiratory:
Asthma ____ Bronchitis ____ Emphysema ____

Cardiovascular:
Hypertension ____ Heart Murmur ____ History of Heart Attack ____ Chest Pain ____ Shortness of Breath ____
Edema (swelling) ____ Palpitations ____

Gastro-Intestinal:
Jaundice ____ Cirrhosis ____ Hepatitis ____ Gastric Ulcers ____ Nausea/Vomiting ____ Painful Urination ____
Blood in the Urine ____ Dialysis ____

Musculoskeletal:
Joint Pain ____ Joint Swelling ____ Muscle Pain ____ Weakness ____ Back Pain ____

Dermatological:
Rash ____ Skin Infection ____ Psoriasis ____ Bruising ____ Hypertrophic Nails ____ Foot Ulcer ____

Neurological:
Paralysis ____ History of Stroke ____ Tremors ____ Seizures ____ Numbness/Tingling ____

Allergic/Immunological:
Allergies ____ Anaphylactic Reactions ____ Immunosuppression ____ Recurring Infections ____
History of Auto-Immune Disease ____

Other: ____

Please record the last year of the following immunizations:

Tetanus ______
Hepatitis ______
Influenza ______
Pneumonia ______

HIPAA Release Form

I hereby authorize payment to Scott Nelson, DPM or Foot & Ankle Medical Clinic, PA of any medical or surgical benefits. I authorize Foot & Ankle Medical Clinic to release medical records, including HIV testing and/or drug/alcohol use and testing, as requested by representatives of insurance companies or other related organizations for payment of claims, for quality assurance/management or utilization management purposes. Despite risk that information transmitted electronically or through facsimile (fax) communication devices may be intercepted or inadvertently transmitted to people not authorized to receive the information, I hereby authorize the transmission of medical records or any part thereof, electronically and through facsimile communication devices. Additionally, I understand that some procedures/ services performed by the physician may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment for such services.

Patient Printed Name: ____Date:___________________

Patient or Responsible Party Signature: ____

Medicare and Insurance Reminders:

- In most cases deductibles begin on January 1 of each year and you may have to fulfill a deductible before Medicare or other insurances will begin to pay claims.
- Per Medicare law, Dr. Nelson cannot accept Medicare as payment in full. A statement will be sent to the financially responsible party for services provided if a balance remains after all insurance payments are received.
- Any insurance co-pays are due at the time of service.

Medical Information Release Form:

I, ____________________, give Foot and Ankle Medical Clinic permission to release medical records
PATIENT NAME
or information about my condition to these persons indicated below.

Name:______________________________________Relationship:____________________

Name:______________________________________Relationship:____________________

Name:______________________________________Relationship:____________________

Patient Signature:____Date:_________

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FOOT & ANKLE MEDICAL CLINIC part of **StrideCare**

Foot & Ankle Medical Clinic is part of StrideCare, a multi-specialty network of practices with a singular focus on lower extremity care. StrideCare offers a comprehensive approach toward prevention and treatment of vascular disease and diabetic foot problems. A team of vascular providers, podiatrists, and wound care specialists work together in a unique care model to identify and treat conditions early. It has been well-documented that early detection and treatment can reduce the risk of amputation and other long-term problems.

Below, you will find important questions that will help us determine whether you are at risk for vascular disease and need an evaluation. If your podiatrist believes that you would benefit from a vascular evaluation, then you will be given the opportunity to book your appointment before you leave the office today.

Patient Name: ______________________________ Date of Birth: ______/______/______

Email Address: ______________________________ Telephone: ______________________

Do you smoke or have a history of smoking? ☐ Yes ☐ No Do you have diabetes? ☐ Yes ☐ No

Have you had a vascular exam in the last 12 months? ☐ Yes ☐ No

If so, by whom? ____

ARE YOU AT RISK FOR VEIN DISEASE?

Question	Yes	No
Do you have unsightly or varicose veins?	☐ Yes	☐ No
Do you feel like you have restless legs?	☐ Yes	☐ No
Do you have itching and dryness of the legs?	☐ Yes	☐ No
Do you ever experience a feeling of heaviness or tiredness in your legs at the end of the day?	☐ Yes	☐ No
Do you have pain/aching in your legs at the end of the day?	☐ Yes	☐ No
Do you have enlarged or protruding veins in your legs that is worse on standing compared to laying down?	☐ Yes	☐ No
Do you have swelling in the legs that is worse at the end of the day?	☐ Yes	☐ No
Do you have swelling in your legs that gets better after a night's rest?	☐ Yes	☐ No
Do you ever have episodes where your legs below the knee get really red or inflamed?	☐ Yes	☐ No
Do you have discoloration/darkening of the legs below your knee?	☐ Yes	☐ No
Do you have heaviness and pain in your legs that feel better with walking or exercise?	☐ Yes	☐ No

Patient Name: ______________________________

ARE YOU AT RISK FOR ARTERY DISEASE?

Question	Yes	No
Have you ever had a heart attack or stroke?	☐ Yes	☐ No
Have you had a stent placed in your heart or been told that you have narrowing or blockages in the arteries of your heart?	☐ Yes	☐ No
Have you had vascular surgery, a balloon angioplasty performed or a stent placed in your legs?	☐ Yes	☐ No
Do you ever have to stop walking because of discomfort (aching, fatigue, tingling, cramping or pain) in thighs, calves or buttocks, that goes away after a short rest?	☐ Yes	☐ No
Do you ever experience discomfort (aching, fatigue, tingling, cramping or pain) in legs/feet when lying down that improves when you stand up or drape leg over side of bed?	☐ Yes	☐ No
Do you have a sore/ulcer on your thigh, calf, ankle, foot or toe that is slow to heal?	☐ Yes	☐ No
Have you ever had a toe or partial foot amputation?	☐ Yes	☐ No
Do you currently or have you had an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?	☐ Yes	☐ No
Do you experience any discomfort (aching, fatigue, tingling, cramping or pain) at rest in your lower legs or feet?	☐ Yes	☐ No
Do you have a history of heart disease, or diabetes, and experience any leg, foot, or toe pain that often disturbs your sleep?	☐ Yes	☐ No
Do you have unusual hair loss or skin discoloration in your legs?	☐ Yes	☐ No
Do your toes feel numb or cold in response to temperature changes or stress?	☐ Yes	☐ No

Recommendations to non-StrideCare vascular providers are available upon request.

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