Terri Quebedeaux, D.P.M.
New Patient Information

LAST NAME:	FIRST:	MIDDLE INITIAL:

Address:	City:	State:
Gender: Male/Female	Date of Birth:	SSN:
Student: Yes/No	Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widow ( ) Other	
Home Phone:	Cell Phone:	Work Phone:
Is it ok to leave voice mail? Yes/No	Is it ok to text? Yes/No	Preferred contact: Phone/Text/Email
Email Address:		
Preferred Language: ( ) English ( ) Spanish ( ) Other:		
Employer:	Occupation/Title	

RACE (check box)
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Two or More of the Above
- ☐ Unknown
- ☐ Decline to Answer

Ethnicity (check box)
- ☐ Not Hispanic, Latino, or Spanish Origin
- ☐ Hispanic, Latino, or Spanish Origin
- ☐ Decline to Answer

Emergency Contact Name: _____
Phone Number: _____
Relation please select: ( ) None ( ) Spouse ( ) Parent ( ) Sibling ( ) Child ( ) Other: _____

INSURANCE INFORMATION	
Primary Insurance Co:	Secondary Insurance Co:
Policy #/ID:	Policy #/ID:
Group #:	Group #:
Subscriber (if not patient):	Subscriber (if not patient):
Subscriber S.S. #:	Subscriber S.S. #:
Relationship to Subscriber: ( ) Spouse ( ) Child ( ) Other	Relationship to Subscriber: ( ) Spouse ( ) Child ( ) Other

Please **circle** the reason(s) for your visit today:

Ankle Break/Sprain	Arch Pain	Bunions	Callouses	Cold extremities	Difficulty walking
Flat Foot	Foot Break /Sprain		Gout	Hammertoe	Heel Pain
High Arches	Ingrown Toenails		Intoeing	Joint Pain	Joint Stiffness
Leg Pain	Neuroma		Numbness	Muscle pain	Tingling in Feet
Rash	Thick Toenails		Paralysis	Tired Feet	Varicose Veins
Warts	Other: _____				

_____

Patient/Guardian Signature: _____ Date: _____

Name_____ DOB_____

HEALTH HISTORY

Please check the boxes below if you have ever had any of the following conditions

Medical History

[ ] Alzheimer's Disease
[ ] Anemia
[ ] Anxiety
[ ] Arthritis
[ ] Atrial Fibrillation
[ ] Asthma
[ ] Back Pain
[ ] Cancer (Type _____)
[ ] Chemical Dependency
[ ] Chest Pain
[ ] Cholesterol Problems
[ ] Circulatory Problems
[ ] Bleeding/Bruising Tendency
[ ] Depression
[ ] Diabetes
[ ] Dizziness
[ ] Ear/Nose/Throat Problems
[ ] Eye Problems (Type _____)
[ ] Fibromyalgia
[ ] Glaucoma
[ ] Headaches
[ ] Head Injury
[ ] Heart Problems / Disease
[ ] Heart Attack (Year _____)
[ ] Hepatitis / Liver Disease
[ ] High Blood Pressure
[ ] HIV / Aids
[ ] Kidney Problems
[ ] Lupus
[ ] Mitral Valve Prolapse
[ ] Parkinson's
[ ] Phlebitis
[ ] Prostate Problems
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Seizures
[ ] Shortness of Breath
[ ] Slow to heal
[ ] Stomach Problems / Ulcers / GERD
[ ] Stroke (Year _____)
[ ] Thyroid Problems
[ ] Tremors
[ ] Tuberculosis

Family History

Please circle:
My mother is ALIVE / Deceased
***If deceased cause of death:
_____
Please circle:
My father is ALIVE / Deceased
*** If deceased cause of death:
_____

Please choose any of the following medical conditions that your parents have or had. Please indicate <u>Mom</u>, <u>Dad</u> or <u>Both</u>

[ ] Cancer_____
[ ] Heart Trouble _____
[ ] Kidney Disease _____
[ ] Arthritis_____
[ ] Diabetes _____
[ ] High Blood Pressure _____
[ ] Strokes _____
[ ] Mental/Emotional Disease _____

Podiatric Surgery

[ ] Ankle Surgery
[ ] Bunionectomy
[ ] Heel Spur Excision
[ ] Hammertoe Repair
[ ] Neuroma Excision
[ ] Plantar Fascial Release
[ ] Spur Excision
[ ] Toenail Surgery
[ ] Other _____

Surgical History

[ ] Appendectomy
[ ] Back Surgery
[ ] Breast Surgery
[ ] Mastectomy (R or L)
[ ] Cardiac Catheterization
[ ] Carotid Artery Surgery (R or L)
[ ] Coronary Bypass Surgery
[ ] Mitral Valve
[ ] Pacemaker
[ ] Carpal Tunnel Release (R or L)
[ ] Cataracts
[ ] Gallbladder Excision
[ ] Gastric Bypass
[ ] Heart Valve Replacement
[ ] Hemorrhoidectomy
[ ] Hernia Repair
[ ] Hip Surgery (R or L)
[ ] Hysterectomy
[ ] Kidney Surgery
[ ] Knee Surgery (R or L)
[ ] Plastic Surgery
[ ] Prostate Surgery
[ ] Shoulder Surgery (R or L)
[ ] Sinus Surgery
[ ] Tonsillectomy
[ ] Thyroid Surgery
[ ] Vein Stripping
[ ] Wisdom Teeth
[ ] Other _____

Social History

Do you smoke? Yes / No
If yes, how much? _____
For how long? _____

If no, have you ever smoked? Yes / No
If YES, when did you stop? _____

Do you drink alcohol? Yes / No
If yes, how much? _____
_____
Do you drink coffee? Yes / No
Do you drink tea? Yes / No
Do you drink soda? Yes / No
Does your occupation involve mostly standing or sitting? _____

Physicians you have seen in the last year: _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

Patient/Guardian Signature: _____ Date: _____

NAME _____

DOB _____

The following information must be filled out monthly, please make sure to bring a list of your current medications with you to EVERY VISIT. Failure to bring a current list of medications can result in your appointment needing to be rescheduled.

MEDICAL INFORMATION	
PCP (Primary Care Physician):	**Height:**
Date of ***last visit*** with PCP:	**Weight:**

Are you allergic to any medications? (**circle one**) YES / NO

Aspirin Codeine Iodine Lidocaine Morphine Penicillin Sulfa
Latex Tape Other: _____

*Women Only: Are you pregnant or planning to become pregnant? If so how far along are you?*_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

NAME OF MEDICATION	DOSAGE	FREQUENCY (times per day)

What pharmacy do you use:

Please **circle** the reason(s) for your visit today:

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Leg Pain	Neuroma		Numbness	Muscle pain	Tingling in Feet
Rash	Thick Toenails		Paralysis	Tired Feet	Varicose Veins
Warts	Other: _____				

Patient/Guardian Signature: _____ Date: _____

NAME _____

DOB _____

TERRI QUEBEDEAUX, D.P.M.

Surgery & Care of the Foot
1345 E. College St.
Seguin, TX 78155
830-303-0005

POLICIES AND ACKNOWLEDGEMENTS

Assignment of Benefits and release of medical information to insurance: I hereby assign to Terri Quebedeaux, D.P.M. any insurance or other third-party benefits available for health care services provided to me. I understand that Terri Quebedeaux, D.P.M., has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Terri Quebedeaux, D.P.M., I agree to forward to Terri Quebedeaux, D.P.M. all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I understand and agree that my medical information may be released to my insurance company for insurance purposes.

Payment Policy: All services rendered are the financial responsibility of the patient at the time services are rendered. **All copays, co-insurance and or deductibles are due at the time services are rendered.** The patient is responsible for payment regardless of insurance status or coverage. I understand and agree that, I the patient am ultimately responsible for the balance on my account for any services rendered and I agree to pay upon demand or as agreed for the related changes of remaining charges following my insurance payment(s). If private pay, I agree to pay for services in full on the date services are rendered.

Missed Appointment Policy: Our practice is dedicated to providing all our patients with the very best healthcare. To do this, your active participation is essential to ensure you obtain quality care. **The minimum requirement for cancellation of an office visit appointment is twenty-four (24) hours prior to the appointment time and seven (7) business days prior to a surgical appointment.** Failure to cancel appointments can result in a charge of $25 for office visit appointments and $75 for surgical appointments. This charge cannot be billed to the insurance company. In addition, after two (2) missed appointments within one (1) calendar year can result in termination from the practice.

Acknowledgement of Review of "Notice of Privacy Practices": I acknowledge that the practice provided me or offered me a written copy of the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions and am entitled to receive a copy of this notice if requested.

Disclosure to Family and Loved Ones: The practice honors the important role that families, friends and other loved ones play in support our patients' health care and treatment. At the same time we are committed to protecting our patients' privacy as well as complying with state and federal law. **Please list below anyone that you would like to be able to speak to the practice on your behalf.**

I authorize Dr. Quebedeaux and/or the practice staff to speak to the following individuals

Name	Relationship

It is the patients' responsibility to notify the practice of any changes to this authorization.

I have reviewed the policies above and do hereby agree with the terms and policies.

Patient/Guardian Signature _____ Date: _____

AGAVE PODIATRY, PLLC

Late Cancellation/No-Show Policy

Effective March 1, 2019

We understand that there are times you must miss an appointment due to emergencies or other obligations. If it is necessary to cancel your scheduled appointment; we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

A late cancellation is when a patient fails to cancel their appointment with a 24 hour notice.

A No-Show is when a patient misses an appointment without canceling.

- First missed/late cancellation appointment; You will receive a phone call and the policy will be explained and the no-show/late cancellation will be noted in your account.
- Second missed/late cancellation; You will receive a final warning notice in the mail.
- Third missed/late cancellation; You will be dismissed from the practice.

I have read and understand the Late Cancellation/No-Show policy of Agave Podiatry.

_____ _____

Patient/Legal Guardian Name (Print) Patient's Date of Birth

_____ _____

Patient/Legal Guardian Signature Date