



Lisa J. Brandy D.P.M.

1801 N. Hampton Road Ste. 340 Desoto, TX 75115 \* Phone: 972-293-9650 \* Fax: 972-291-2533

Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ ( ) Male ( ) Female

Full Name \_\_\_\_\_

Last First Middle

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check which you prefer to be called on first:

( ) Cell Phone ( ) Home ( ) - ( ) -

Email \_\_\_\_\_

Marital Status (circle one) : Married Single Widowed Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) -

Pharmacy \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_

Pharmacy Ins.: \_\_\_\_\_ ID# \_\_\_\_\_ Phone# \_\_\_\_\_

Whom may we release medical information to: \_\_\_\_\_

How can we contact you? (Circle ALL that apply) Phone Mail E-mail Text Message

Primary Language: (Circle one) English Spanish Other: \_\_\_\_\_

Okay to leave message with: (Circle one) Self only Patient and/or spouse Anyone answering phone

Race: ( ) White ( ) Native Hawaiian or Other Pacific Islander ( ) Asian ( ) Black or African American ( ) American Indian or Alaskan Native ( ) Decline

Ethnicity: ( ) Not Hispanic or Latino ( ) Hispanic or Latino ( ) Decline

(Circle One)

How did you hear about us? Friend Google Doctor Referral Facebook Insurance Internet Other: \_\_\_\_\_

Insurance Information:

Primary Ins: \_\_\_\_\_ ID or Policy No.: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ ID or Policy No.: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last First

Notification of Changes

If/when any of the above information, (i.e. name, phone number, insurance,) changes, I will provide the updated information promptly.

X \_\_\_\_\_ DATE \_\_\_\_\_

Patient's Signature or Parent/ Legal Guardian



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**MEDICAL HISTORY**

**PATIENT NAME:** \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE# \_\_\_\_\_ Last seen: \_\_\_\_\_

DIABETIC PATIENTS: Doctor who treats your Diabetes: \_\_\_\_\_ Last seen: \_\_\_\_\_

WOULD YOU LIKE YOUR PRIMARY DOCTOR TO RECEIVED NOTES FROM YOUR VISIT TODAY? YES or NO

STATE IN YOUR OWN WORDS YOUR MEDICAL REASON(S) FOR COMING INTO OUR OFFICE:

\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL MEDICATIONS THAT YOU CURRENTLY USE:

\_\_\_\_\_  
\_\_\_\_\_

**For ALL patients:** Has the patient received a flu vaccination for the current season? Yes No

If No, What is the reason?: \_\_\_\_\_ Patient allergy \_\_\_\_\_ Patient declined \_\_\_\_\_ Vaccine unavailable

**For those patients of 65 years age or older:** Do you have a living will or someone to make decisions on your behalf? Yes No

Have you had a pneumonia vaccination? Yes No

**MOTHER** has had any of the following diseases: **Circle ALL that apply:** Diabetes High Blood Pressure Heart Trouble Kidney Disease None

**FATHER** has had any of the following diseases: **Circle ALL that apply:** Diabetes High Blood Pressure Heart Trouble Kidney Disease None

**Have YOU ever HAD or HAVE any of the following?**

YES	NO	ALCOHOLISM	YES	NO	GOUT
YES	NO	ALLERGIES/HAYFEVER	YES	NO	HEART DISEASE
YES	NO	ANEMIA	YES	NO	HIGH BLOOD PRESSURE
YES	NO	ARTHRITIS	YES	NO	HIV/AIDS
YES	NO	ASTHMA	YES	NO	KIDNEY DISEASE
YES	NO	CANCER	YES	NO	LUNG/COPD
YES	NO	DIABETES	YES	NO	STOMACH ULCER/GERD
YES	NO	DRUG ABUSE	YES	NO	STROKE
YES	NO	EPLIEPSY/SEIZURE	YES	NO	THYROID
YES	NO	EYE (CATARACT/GLAUCOMA)	YES	NO	TROUBLE WITH HEARING

**ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED TO ANY OF THE FOLLOWING?**

YES	NO	ASPRIN	YES	NO	LIDOCAINE (LOCAL ANESTHESIA)
YES	NO	BAND-AIDS/ TAPE	YES	NO	SULFA DRUGS
YES	NO	LATEX	<b>OTHER:</b> _____		

**FOR WOMEN ONLY:** ARE YOU PREGNANT? \_\_\_\_\_ IF SO HOW MANY MONTHS? \_\_\_\_\_

X \_\_\_\_\_ **DATE** \_\_\_\_\_  
Patient's Signature or Parent/ Legal Guardian



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PATIENT NAME: \_\_\_\_\_

**Authorization for Insurance to Pay**

I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Trinity Foot Center, PC, the office of Lisa J. Brandy, DPM. I hereby agree to promptly pay for any service(s) provided to me not covered by my insurance policy. I agree to pay all co-payments, deductibles, coinsurance, and products sold through Trinity Foot Center, PC.

I authorize the above named provider to release to the Social Security Administration or its intermediaries any information needed for the claim or related medical claim. I further permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for the charges not covered by my insurance program.

**Non-Covered Services**

It is important to understand that some of the services provided to you may not be covered under your current insurance plan. Therefore, it is important that you check with your insurance company to verify your benefits. You will be responsible for full payment of any services not covered by your insurance at the time of your visit.

**Surgery**

Some minor surgical procedures are performed in our office. Most insurance carriers put these in the category of “surgery”, meaning that the procedure may be applied to a surgical deductible or coinsurance. Therefore, you may be billed for an amount over and above the usual visit co-payment at your visit. If the procedure is not covered by your insurance, we will require 100% payment at the time of the surgery.

**Appointments**

It is our goal to provide services to you in the most comfortable and timely manner possible. In order to achieve this, we ask that you be on time for your appointments. We realize your time is valuable and we endeavor to keep on schedule, while providing each patient with personalized care. However, emergencies do occur, and may cause delays in our schedule. We will try to keep you informed of these delays should they arise. **If you must cancel an appointment, we ask that you kindly notify us at least 24 hours in advance. There is a \$25 fee for each no show occurrence.**

**Prescription Refills**

**Prescription refills or change requests will be handled within 24 hours of the receipt of the request during regular office hours.** Please contact your pharmacy so that a written request can be faxed to our office. No prescription refill or change requests will be handled after regular office hours or on the weekend.

**Acknowledgment of Receipt of Notice of Privacy Practices**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so chose) and understood the notice.

Thank you for choosing us for your foot care needs. If you have any questions regarding these policies, please notify a member of our business office during regular hours. We will do our best to ensure your understanding of our policies so that we may concentrate on you and your care. I acknowledge that I have read and understand the contents of the financial and office policies for Trinity Foot Center, PC.

X \_\_\_\_\_ DATE \_\_\_\_\_  
Patient’s Signature or Parent/ Legal Guardian