Steven J. Lieberson, D.P.M., P.C.
Fellow, American College of Foot and Ankle Surgeons
Diplomate, American Board of Foot and Ankle Surgery
Podiatrist - Foot Specialist

17510 W. Grand Parkway S. Suite 340
Sugar Land, TX 77479
Office (281) 242-3233 / Fax (713) 654-7095

Welcome to our office!

ALL INFORMATION IS STRICTLY CONFIDENTIAL / ***PLEASE PRINT NEATLY!! ***

PATIENT INFORMATION:

PATIENT NAME: _____ D.O.B.: _____ GENDER: ☐ M ☐ F

PREFERRED NAME: _____ MARITAL STATUS: ☐ Single ☐Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

HOME ADDRESS: _____
Street Apt# City, State, Zip

HOME PHONE #: _____ CELL PHONE #: _____

E-MAIL: _____

EMPLOYMENT STATUS: ☐ Part-Time ☐Full-Time ☐ N/A STUDENT STATUS: ☐ Part-Time ☐Full-Time ☐ N/A

PRIMARY LANGUAGE SPOKEN: _____ ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Decline

RACE: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Other ☐ Decline

HOW DID YOU LEARN ABOUT OUR OFFICE? _____

EMERGENCY CONTACT:

NAME: _____ PHONE #: _____ RELATIONSHIP: _____

INSURANCE INFORMATION: **☐ CASH PAY**

NAME OF INSURANCE: _____ TYPE OF PLAN: ☐ HMO ☐ PPO

GUARANTOR / INSURED NAME: _____ GUARANTOR / INSURED D.O.B.: _____

MEMBER ID / POLICY # _____ GROUP#: _____

SECONDARY INSURANCE: **☐ N/A**

NAME OF INSURANCE: _____

GUARANTOR / INSURED NAME: _____ GUARANTOR / INSURED D.O.B.: _____

MEMBER ID / POLICY # _____ GROUP#: _____

PHARMACY INFORMATION:

PHARMACY NAME: _____ PHARMACY PHONE #: _____

ADDRESS: _____

Street Apt# City, State, Zip

PRIMARY CARE PHYSICIAN:

NAME: _____ PHONE #: _____

ADDRESS: _____

Street Apt# City, State, Zip

DATE LAST SEEN: _____

ARE YOU OR DO YOU THINK YOU ARE PREGNANT?: ☐ N/A ☐ No ☐ Yes If yes, how many weeks? _____

For patients 65 years or older: Do you have a living will or someone to make decisions on your behalf? ☐ N/A ☐ No ☐ Yes

SOCIAL HISTORY:

Tobacco / nicotine / E-cig / Vape Use: ☐ Yes, Times per day: _____ ☐ No, **Never** ☐ No, **Former** Smoker

Alcohol Use: ☐ Never ☐ Social ☐ Occasional ☐ Moderate ☐ Heavy ☐ Recovering Alcoholic

Recreational Drug Use: ☐ Never ☐ Occasional ☐ Often ☐ Recovering Addict

Exercise: ☐ Moderate ☐ Never ☐ Often

HISTORY OF PRESENT ILLNESS:

REASON FOR TODAY'S VISIT: _____

_____

_____

_____

DATE OF ONSET / INJURY: _____

SYMPTOMS: ☐ Pain ☐ Swelling ☐ Infection ☐Other: _____

LOCATION OF SYMPTOMS: ☐ Right ☐ Left ☐ Both

PREVIOUS TREATMENTS: ☐ Medication ☐ Stretching ☐ Change of Shoes ☐ Surgery ☐ Other _____

HAVE YOU EXPERIENCED THIS PROBLEM BEFORE: ☐ Yes ☐ No If yes, when: _____

CURRENT PAIN LEVEL: ☐ Mild ☐ Moderate ☐ Severe

HOW MANY HOURS PER DAY DO YOU SPEND ON YOUR FEET?: _____

WHAT TYPE OF SHOES DO YOU WEAR DAILY?: _____

REVIEW OF SYSTEMS:

Are you **currently** (today) experiencing any of the following signs or symptoms? If yes, please describe:

SYMPTOMS:	Yes	No	Describe all "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)	☐	☐	
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	☐	☐	
Cardiovascular (e.g. chest pain, palpitations, ankle swelling)	☐	☐	
Respiratory (e.g. shortness of breath, bronchitis, asthma)	☐	☐	
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)	☐	☐	
Genitourinary (e.g. burning, bleeding, difficulty breathing)	☐	☐	
Musculoskeletal (e.g. joint, muscle, back pain)	☐	☐	
Skin (e.g. acne, psoriasis, cellulitis)	☐	☐	
Neurological (e.g. numbness, tingling, weakness)	☐	☐	
Mental Health (e.g. depression, anxiety, memory loss)	☐	☐	
Endocrine (e.g. weight loss / gain, excess thirst / urination)	☐	☐	
Hematologic (e.g. bleeding / clotting disorder, anemia)	☐	☐	

PAST MEDICAL and FAMILY HISTORY: ☐ **ADOPTED**

Have you or an immediate family relative **(Mother, Father, Sister, Brother ONLY)** been diagnosed with any of the following?

Please circle applicable disease / condition

DISEASE / CONDITION:	Self	Family	Family Member
Anemia / Sickle Cell Anemia	☐	☐	
Angina / Heart Attack / Cardiomyopathy	☐	☐	
Arthritis / Osteoporosis	☐	☐	
Asthma / COPD / Emphysema	☐	☐	
Bleeding / Clotting Disorder	☐	☐	
Cancer	☐	☐	
Diabetes Mellitus	☐	☐	
GERD / Ulcers / Colitis	☐	☐	
Hepatitis / Liver / Gall Bladder	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
HIV / AIDS	☐	☐	
Kidney Failure / Stones	☐	☐	
Psoriasis / Eczema	☐	☐	
Psychiatric / Mental Disorder	☐	☐	
Stroke / TIA / Seizures	☐	☐	
Thyroid / Endocrine Problem	☐	☐	
Tuberculosis	☐	☐	

PAST SURGICAL HISTORY:

SURGICAL PROCEDURE	YEAR	SURGICAL PROCEDURE	YEAR
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/ Stent		☐ TURP	
☐ Appendectomy		(Trans-urethral resection of Prostate)	
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other:	
☐ CABG (Heart Bypass)		☐ Other:	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Breast Biopsy	
☐ Gastric Bypass		☐ Cesarean Section	
☐ Hernia Repair		☐ D and C	
☐ Hip Replacement		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH / BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other:	
☐ Tonsillectomy		☐ Other:	
☐ Other:		☐ Other:	
☐ Other:		☐ Other:	

PAST SURGICAL HISTORY & HOSPITALIZATIONS:

REASON	DATE

PATIENT NAME: _____

MEDICATIONS:

PATIENT NAME: ____________________ DATE OF BIRTH: ____________

MEDICATION NAME	DOSE (mg, mcg, etc.)	REASON FOR MEDICATION

ALLERGIES:

☐ **NO KNOWN DRUG ALLERGIES**

NAME OF DRUG	REACTION (i.e. trouble breathing, rash, etc.)	SEVERITY
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
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		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

☐ **NO KNOWN FOOD ALLERGIES**

NAME OF FOOD	REACTION (i.e. trouble breathing, rash, etc.)	SEVERITY
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

To the best of my knowledge, the information provided on all pages is accurate and complete. I understand it is my responsibility to inform my doctor if I, or my child, ever has a change in health.

Signature Of Patient Or Parent/Guardian: _____

Printed Name: _____ Date: _____

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FINANCIAL RESPONSIBILITY AGREEMENT

I will be financially responsible for the medical expenses that I incur if my insurance eligibility cannot be verified at the time of my visit, and/or if it is determined by my insurance company that the services provided are not a covered benefit. I understand that when I am billed for these services, I am expected to make payment in full or arrange with the business manager to make payments in a timely manner. If I do not, then I understand that my account will be reviewed and could be placed with a collection agency. Court costs and reasonable collection fees could be added to my balance. I also understand that nonpayment could result in my account being reported to the credit bureau. Any hospital, anesthesia, radiology, or associated lab fees are payable separately and not included with the fees associated with the services provided by the rendering physician or his staff. Please contact the facility to obtain their fee information.

_____
Patient or Responsible Party Signature

_____
Date

_____
Witness

INITIALS

_____Assignment of Benefits

I hereby authorize payment directly to Dr. Lieberson of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

_____Authorization to Release Information

I authorize Dr. Lieberson to release any and all information contained in my complete medical and billing record to:

1) my insurance company or its representatives
2) other persons or entities financially responsible for my care or treatment
3) the Medicare or Medicaid programs and their fiscal intermediaries, if applicable or otherwise required or permitted by laws, regulation, and/or
4) Federal or state agencies, required or permitted by laws or regulation

My signature indicates I have read and understand all the preceding information.

Patient Name: _____ Patient or Responsible Party Name: _____

Signature: _____ Date: _____

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CONSENT FOR RELEASE OF INFORMATION

I have read the NOTICE OF PRIVACY PRACTICES. I am aware that my "Protected Health Information" (PHI) will be disclosed to those physicians involved in my care, my insurance company(ies) and business associates of the practice, for the purposes of carrying out treatment, payment or health care operations. In addition, I have specified my preferences for routine uses and disclosures, as indicated below.

NAME: _____ D.O.B.: _____

Please check any/all of the following methods that would be appropriate for our office.

☐ ADDRESS _____
Street Apt# City, State, Zip

☐ HOME # _____ ☐ WORK # _____

☐ CELL # _____ ☐ EMAIL: _____

Is it suitable to leave a message? (CHECK ALL THAT APPLY)

☐ voicemail ☐ with adult household member ☐ exclusively with patient

Who is authorized to receive patient medical/billing information? (CHECK ALL THAT APPLY)

☐ patient only ☐ spouse ☐ family member (name) _____

☐ other (please specify) _____

☐ I DO NOT wish to grant authorization of any of my information to any family members / personal representatives

I understand that further authorization(s) may be necessary, as required by law, should an additional disclosures of my PHI be requested.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Date

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Dr. Steven J. Lieberson, D.P.M., P.C. has provided you access to its Privacy Notice, which explains how your health information will be handled in various situations. Upon request, a hard copy will be issued. By law, we are required to have you sign this form on your first date of service with us.

*** The Practice has provided me access to its Privacy Notice. I understand I may request a copy for my personal use.

_____ _____

Patient's Signature Date

_____

Print Patient's Name

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OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

To assist us in establishing your financial account with us, the following must be done:

- COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DOCTOR.
- CO-PAY AND DEDUCTIBLE PAYMENTS ARE DUE AT THE TIME OF SERVICE.
- PAYMENT CAN BE IN THE FORM OF CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMEX.

MINORS ACCOMPANIED BY AN ADULT

The parents (or guardians) accompanying a minor are responsible for full payment at time of service.

REGARDING INSURANCE

If you have insurance, we will assist you in receiving maximum benefits. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

On major surgery or office visits, we may accept your insurance if we obtain approval from your insurance prior to the date of service. If your insurance company has not paid the FULL BALANCE within 60 days, you have 30 days to pay the balance.

PPO/HMO

Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan. Verification of your plan is required. Therefore, you must show your current card to our receptionist each visit.

MEDICARE/MEDICAID

The federal government requires that all Medicare/Medicaid claims be filed by your physician. Therefore, you must come to our office each visit to show your Medicare/Medicaid card. We regret the inconvenience, but in order for you to receive your Medicare/Medicaid benefits the federal government requires that all the rules are followed to their specifications.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Patient Signature: _____ Date: _____