Kent Stahl, DPM, PLLC
6115 Muela Creek Dr., Ste C
Beaumont, TX 77706

Name _____ _____ / _____ / _____ _____
First Middle Last Date Of Birth Age

SSN: _____ - _____ - _____ Marital Status: S M W D Gender: M F

Address: _____
Street City State Zip

Hm Phone (_____) _____ - _____ WK (_____) _____ - _____ Cell (_____) _____ - _____

I consent to be contacted by: (circle all that apply) Phone Text Email: _____

Employer/Occupation: _____

SPOUSE / Parent Name (if child is patient) _____ Birth Date _____ / _____ / _____

Address (if different from above) _____
Street City State Zip

Hm Phone (_____) _____ - _____ WK (_____) _____ - _____ Cell (_____) _____ - _____

Primary Physician's Name: _____ Date last seen: _____ / _____ / _____

Emergency Contact: _____ / _____ Phone # (_____) _____ - _____
(Relationship)

INSURANCE INFORMATION

1. _____ _____ _____ / _____ / _____ _____
Primary Insurance Policy Holder Name Policy Holder DOB Relation to Patient

_____
Member/Policy ID # Group #

2. _____ _____ _____ / _____ / _____ _____
Secondary Insurance Policy Holder Name Policy Holder DOB Relation to Patient

_____
Member/Policy ID # Group #

*Medicare Number _____ Are you working? Yes No

Reason for Visit: _____ LEFT / RIGHT

I hereby authorize payment directly to Dr. Kent Stahl for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize Dr. Kent Stahl and /or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all submissions.

SIGNATURE of Responsible Party: _____ Date: _____

PAST MEDICAL HISTORY

HEAD
____ Trauma

EYES
____ Blindness
____ Cataracts
____ Glaucoma
____ Wears Glasses/Contacts

CARDIOVASCULAR
____ Aneurysm
____ Angina
____ DVT
____ Hypertension (BP)
____ Myocardial Infarction
____ Other Heart Disease

RESPIRATORY
____ Asthma
____ Bronchitis
____ COPD/Emphysema

GASTROINTESTINAL
____ Cirrhosis
____ GERD
____ Gallbladder Disease
____ Heartburn
____ Hepatitis
____ Ulcer (stomach)

GENITOURINARY
____ Hernia
____ STDs
____ UTIs
____ other kidney disease

MUSCULOSKELETAL
____ Arthritis
____ Gout
____ M/S injury

SKIN
____ Dermatitis
____ Mole(s)
____ Psoriasis
____ other skin condition(s)

NEUROLOGICAL
____ Stroke
____ TIA

PSYCHIATRIC
____ Bipolar disorder
____ Depression

ENDOCRINE
____ Hyperlipidemia
____ Hypothyroidism
____ Thyroid Disease
____ Thyroiditis
____ Type 1 Diabetes
____ Type 2 Diabetes

HEME/ONCOLOGY
____ Anemia
____ Cancer

INFECTIONS
____ HIV
____ STDs

OTHER: _____

SURGICAL HISTORY

____ Appendectomy
____ Back Surgery
____ Bariatric SX/Gastic Bypass
____ CABG
____ Carotid Endartectomy/Stent
____ Cataract Surgery
____ Cholystectomy/Gallbladder
____ Hysterectomy
____ Hernia Repair
____ Tonsillectomy/Adenoids
____ Pacemaker/Defibrillator
____ Spinal Fusion
____ TURP
____ Other
_____

FAMILY HISTORY

____ Arthritis
____ Asthma
____ Bleeding Disorder
____ CAD
____ Cancer
____ COPD
____ Diabetes
____ Heart Attach
____ Heart Disease
____ High Cholesterol
____ Hypertension
____ Mental Illness
____ Osteoporosis
____ Stroke

SOCIAL HISTORY

TOBACCO
____ Current daily smoker
____ Current occassional smoker
____ Former smoker
____ Never smoked

ALCOHOL
____ Do Not Drink
____ Drink daily
____ Drink frequently
____ Drink occassionaly

DRUG ABUSE
____ IV drug use
____ Illicit drug use
____ No illicit drug use

SEXUAL ACTIVITY
____ Exposure to STI/STD

Are you pregnant: Yes No Any abnormal bruising: Yes No Do you have any vascular grafts: Yes No

Height: _____ Weight: _____ Shoe Size: _____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature of Patient/Responsible Party: _____ Date: _____

Patient:_____ Date of Birth:_____

Preferred Pharmacy:_____ Phone #_____

Location of Pharmacy:_____

(A copy or list of allergies and current medications may be given to our staff at check-in)

Drug Allergies: _____ No Known Drug Allergies

CURRENT MEDICATIONS

(please include dosage)

_____ _____

Patient/Guardian Signature Date

Consent for Disclosure of Protected Health Information

With this consent, representatives of Kent Stahl, DPM, PLLC may call or mail my home or other alternative location, or leave a message on voicemail in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointments, discussion of lab, radiology, or procedure results, or to ask to call regarding an issue or concern.

I authorize Kent Stahl, DPM, PLLC and his staff to release laboratory/radiology results and reports to the following individuals listed below. At no time will a representative of Kent Stahl, DPM, PLLC discuss your medical circumstances or condition without your consent.

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

This authorization shall be in force and effect until one year from the date of signature. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

6115 Muela Creek Dr., Suite C

Beaumont, Texas 77706

_____ **No, I do not wish my information to be released to anyone but myself.**

By signing this form, I acknowledge that the Notice of Privacy Practices was available and that I have read (or had the opportunity to read if I choose) and understand the notice.

By signing this form, I am consenting to allow Kent Stahl, DPM, PLLC and his office staff to use and disclose my personal health information to carry out treatment, payment, and health care operations. I also accept full financial responsibilities for any services not covered by my insurance policy/policies.

_____ _____

Patient Name Date

OFFICE AND FINANCIAL POLICIES

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office staff.

Health Insurance
We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with the insurance company and will only collect your copay, deductible, and/or coinsurance when it applies. **Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit.**
If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service.

Patient Payments
In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from this office unless prior arrangements have been made. I understand that there will be a $35.00 NSF fee for any returned checks.

Referrals
It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

Disability and Insurance Forms
There is a $40.00 fee to fill out disability and insurance forms. Please mail or leave them at the front desk along with your payment. Forms will not be completed until payment is received. **Please allow at least 5 business working days for processing.** We will contact you once we have completed your request.

Release and Obtain Medical History
I hereby authorize Dr. Stahl to receive and release any medical or surgical information necessary for the treatment of my medical or surgical conditions and in order to process any and all insurance claims on my behalf.

Medical History Authority
I grant Dr. Stahl and his staff the authority to download my medication history automatically from Surescripts. This medication history may include prescriptions from all of my treating physicians within the last 12-month period.

I have read and understand the office policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. I hereby assign my insurance benefits to be paid directly to Kent Stahl, DPM, PLLC.

_____ _____

Signature of Patient or Responsible Party Date

No Show, Missed Appointments

Office Policy Form

Kent Stahl, DPM, PLLC

NO SHOW

We understand that there are times when you must miss an appointment due to unforeseen circumstances. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Please contact our office within 24 hours of your scheduled appointment or as soon as you are aware you will miss your appointment.

***There is a charge of $30.00 for each No Show appointment. This charge is not covered by your insurance and will be applied to your account.**

LATE

Please contact the office if you will be more than 20 minutes late. We understand that delays can happen, however, we must maintain a timely schedule for other patients and for Dr. Stahl. Depending on the needs of our other patients and Dr. Stahl's schedule your appointment may be rescheduled to another day. Our office will work diligently with you to see you the same day.

***We reserve the right to charge you a NO SHOW fee if you do not inform us that you will more than 20 minutes late.**

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

_____

_____

Patient Name

_____ _____

Patient Signature **Date**