
# *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 |

HOW DID YOU HEAR ABOUT US: Doctor Referral ___ Insurance ___ Friend/Family ___ Internet/Google ___

Referred by: _____ 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: _____

The following information must be filled out monthly.

**<u>Please make sure to bring a list of your current medications with you to EVERY VISIT</u>**.

Failure to bring a current list of medications can result in your appointment needing to be rescheduled.

PATIENT NAME:_____ PATIENT DATE OF BIRTH: _____

| MEDICAL INFORMATION | |
|---|---|
| **PCP (Primary Care Physician):** | **Height:** |
| Date of ***last visit*** with PCP: | **Weight:** |
| **Name of Pharmacy:** | **Phone number:** |

## PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

| NAME OF MEDICATION | DOSAGE | FREQUENCY (times per day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

SMOKER FORMER SMOKER NEVER SMOKED || FLU SHOT? YES NO, WHY? _____

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

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

Please **<u>circle</u>** the reason(s) for your visit today:

| | | | | |
|---|---|---|---|---|
| Ankle Break / Sprain | Flat Foot | Ingrown Toenail(s) | Neuroma | Tired Feet |
| Arch Pain | Foot Break / Sprain | Intoeing | Numbness | Varicose Veins |
| Bunions | Gout | Joint Pain | Paralysis | Warts |
| Callouses | Hammertoe | Joint Stiffness | Rash | Wound |
| Cold Extremities | Heel Pain | Leg Pain | Thick Toenails | Other: _____ |
| Difficulty Walking | High Arches | Muscle Pain | Tingling in Feet | Other: _____ |

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

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

AGAVE PODIATRY, PLLC

## Late Cancellation/No-Show Policy

## Effective January 1, 2023

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 48 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 48 hour notice.

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

A $50.00 fee will be charged to all patients who no show or do not provide 48 hour notice to cancel appointment.

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

_____ _____

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

_____ _____

Patient/Legal Guardian Signature Date

AGAVE PODIATRY PLLC

***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 Teresa Quebedeaux, D.P.M. and Agave Podiatry, PLLC, any insurance or other third-party benefits available for health care services provided to me. I understand that Teresa Quebedeaux, D.P.M. and Agave Podiatry, PLLC, has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Teresa Quebedeaux, D.P.M. and Agave Podiatry, PLLC, I agree to forward to Teresa Quebedeaux, D.P.M. and Agave Podiatry, PLLC, 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.

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

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

| Name | Relationship |
|---|---|
| | |
| | |
| | |
| | |
| | |

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

Patient Name _____ Patient Date of Birth _____

Patient/Guardian Signature _____ Date: _____