Dr. Japera Levine D.P.M.
350 Pine St. Suite 1420
Beaumont TX 77701

Patient Information Form
Please Print-Mark "N/A" If It Does Not Apply To You
ALL FIELDS ARE MANDATORY

Date of Service: ____________________

Full Name: ______________________________ Date Of Birth: ________________
Last First Middle

Gender: ☐ Male ☐ Female Social Security#: ____________________ Shoe Size: __________

Race:

	American Indian/Native		Asian		Black/African American
	Caucasian/White		Hispanic/Latino		Hawaiian/Pacific Islander

Home Phone/Alternate Number: ____________________ Cell Phone: ________________

Mailing Address: ____
Street Address City Zip

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer: ______________________ Title/Occupation: ______________________

Pharmacy: ________________ Location: ________________ Phone #: ________________

Emergency Contact Name (Not Living In The Your Home): ______________________

Relation: ______________________ Phone: ______________________

Primary Care Physician: ______________________ Phone: ________________

When Did You Last See Your PCP? ________________

Pain Management Physician: ______________________ Phone: ________________

When Did You Last See Your Pain Management? ________________

Responsible For Payment (Full Name): ________________ Date Of Birth: ____________ SSN: ____________

Insurance 1st: ______________________ Policy #: ______________________

Policy Holder & Relationship: ______________________ Group#: ______________________

Date Of Birth: ______________________ SSN: ______________________

Insurance 2nd: ______________________ Policy #: ______________________

Policy Holder & Relationship: ______________________ Group#: ______________________

Date Of Birth: ______________________ SSN: ______________________

Is This Workers Comp? ☐ Yes ☐ No Date of injury: ________________ Employer: ________________

REASON FOR VISIT TODAY? **BE SPECIFIC** ______________________________

PEDIATRIC PATIENT ONLY:

Is your condition getting Better/Worse? Explain: ______________________________

Does the problem involve both sides of the body? ______________________________

Is there leg or foot pain in rest and/or with certain activities? ______________________________

Any current or past treatment for leg or foot pain? ______________________________

If yes, were there any successful treatments for them? ______________________________

Any significant Medical Problems: Including Medications, Trauma, or Surgery involving the mother during the time of the pregnancy? ______________________________

Any significant issues during delivery? ______________________________

Did you have any issues meeting any of developmental milestones at the appropriate time? ________________

Do you have any issues with school, speech or learning? ______________________________

From a parent's perspective have you ever been concerned at all with any part of your child's lower Extremity/Type of Walk/Look of feet prior to today's visit? ______________________________

Does your child have any issues with fatigue, endurance, speed, posture or general strength? ________________

FAMILY HISTORY- PLEASE LIST ANY MEDICAL HISTORY THAT YOUR FAMILY MAY HAVE THAT MAY OR MAY NOT BE FOOT RELATED:

RELATION TO PATIENT	LIST RELATED HISTORY BELOW	LIVING	DECEASED
FATHER			
MOTHER			
SPOUSE			
SON			
DAUGHTER			

PATIENT'S MEDICAL HISTORY- PLEASE CIRCLE "Y" FOR YES/"N" FOR NO

ACID REFLUX	YES	NO	FIBROMYALGIA	YES	NO	OPEN SORES	YES	NO
ANEMIA	YES	NO	GOUT	YES	NO	PNEUMONIA/VACCINE	YES	NO
ARTHRITIS	YES	NO	HEART ATTACK	YES	NO	POLIO	YES	NO
ASTHMA	YES	NO	HEART DISEASE	YES	NO	HEART FAILURE	YES	NO
BACK TROUBLE	YES	NO	HEPATITIS	YES	NO	SICKLE CELL DISEASE	YES	NO
BLADDER INFECTIONS	YES	NO	HIV/AIDS	YES	NO	SKIN DISORDER	YES	NO
ABNORMAL BLEEDING	YES	NO	HIGH BLOOD PRESSURE	YES	NO	SLEEP APNEA	YES	NO
BLOOD CLOTS	YES	NO	KIDNEY DISEASE	YES	NO	STOMACH ULCERS	YES	NO
BLOOD TRANSFUSION	YES	NO	LIVER DISEASE	YES	NO	STROKE	YES	NO
BRONCHITIS	YES	NO	LOW BLOOD PRESSURE	YES	NO	THYROID DISEASE	YES	NO
CANCER	YES	NO	MIGRAINES/HEADACHES	YES	NO	TUBERCULOSIS	YES	NO
DIABETES	YES	NO	MITRAL VALVE PROLAPSE	YES	NO	INFLUENZA VACCINE	YES	NO
DATE OF LAST HEMOGLOBIN A1C			KELOIDS	YES	NO	NEUROPATHY	YES	NO
VALUE OF LAST HEMOGLOBIN A1C			OTHER:			OTHER:		
WEIGHT LOSS SURGERY	YES	NO	OTHER:			OTHER:		

PATIENT'S SOCIAL HISTORY

USE OF ALCOHOL- TYPE: ______________ ☐ Social ☐ Occasional ☐ Light ☐ Heavy ☐ Never

USE OF TOBACCO: ☐ Never ☐ Smoke–How long? _____ ☐ Quit - How long? _____ WOULD YOU LIKE TO QUIT SMOKING? _____

HAVE YOU TRIED TO QUIT SMOKING PREVIOUSLY? _____ HOW MANY TIMES HAVE YOU TRIED TO QUIT SMOKING? _____

USE OF RECREATIONAL DRUGS: ☐ Never ☐ Current User – Type: ______________ ☐ Quit - How long? _________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN – AGE (S): ______________

☐ PET (S)–WHAT KIND? ______________ ☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER: ______________

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: ______________

PATIENT'S SURGICAL HISTORY

TYPE OF SURGERIES (PLEASE LIST RIGHT OR LEFT)	YEAR

Review Of Systems- Please Check All That Apply

CONSTITUTIONAL:	YES	NO	URINARY:	YES	NO	BREAST:	YES	NO
Chills			Awakening To Urinate			Discharge		
Fever			Burning			Lumps		
Weight Loss/Gain			Flank Pain			Tenderness		
Weakness			Infections			Pain		
Fatigue			Stones					
			Urine Odor			**Skin:**		
Head:			Bed-Wetting			Dryness		
Dizziness			Difficulty Starting Stream			Itching		
Fainting			Frequency			Nail Appearance Change		
Pain			Urgency			Skin Color Change		
Head Injury			Blood In Urine			Easily Bruised		
Sweats			Excessive Urination			Hair Texture Change		
			Incontinence			Nail Texture Change		
Eyes:			Retention			Eczema		
Blurry/Double Vision			Urine Discoloration			Mole Increased Size		
Eyeglass Use						Rashes		
Pain W/ Light			**Cardiovascular:**					
Unusual Sensation			Chest Pain			**Neurological:**		
Cataracts			Hair Loss On Legs			Blackouts		
Excessive Tearing			Swelling Of Legs			Fainting		
Glaucoma			Varicose Veins			Loss Of Consciousness		
Recent Injury			Cold Extremities			Paralysis		
Vision Loss			Heart Murmur			Tingling		
Discharge			Thrombophlebitis			Burning		
Eye Pain			Discolored Extremities			Speech Disorder		
Infections			Heart Tests			Tremors		
Redness			Rheumatic Fever			Numbness		
			Ulcer On Legs			Unsteady Gait		
Nose:			Palpitations					
Discharge						**Endocrine:**		
Sinus Infections			**Gastrointestinal:**			Cold Intolerance		
Frequent Colds			Change In Stool Color			Goiter		
Nasal Obstructions			Decreased Appetite			Neck Pain		
Nosebleeds			Excessive Thirst			Weakness		
			Hemorrhoids			Heat Intolerance		
Ears:			Jaundice			Fatigue		
Discharge			Nausea			Increased Thirst		
Hearing Impairment			Swallowing Problem					
Ringing In Ears			Change In Frequency Of Bm			**Allergic/Immunologic:**		
Infections			Diarrhea			Coughing		
Hearing Aid			Gallbladder Disease			Itchy Eyes		
Pain			Laxative Use			Runny Nose		
			Rectal Bleeding			Watery Eyes		
Throat/Neck:			Vomiting			Coughing W/ Exercise		
Sore Throat			Antacid Use			Itchy Nose		
Enlarged Tonsils			Constipation			Sneezing		
Lumps			Excessive Hunger			Wheezing		
Tenderness			Heartburn			Hives		
			Infections			Recurrent Infections		
Respiratory:			Rectal Pain			Stuffy Nose		
Coughing Blood			Vomiting Blood			Wheezing W/ Exercise		
Sputum			Abdominal Pain					
Pain						**Psychiatric:**		
Cough			**Musculoskeletal:**			Behavioral Changes		
Shortness Of Breath			Restricted Motion			Disturbing Thoughts		
Palpitations			Joint Pain			Memory Loss		
Exertion			Muscle Stiffness			Psychiatric Disorders		
			Weakness			Depression		
Hematological/Lymph			Deformities			Excessive Stress		
Swollen Glands			Joint Stiffness			Mood Changes		
Bleeding Easily			Paralysis			Disorientation		
Lumps			Muscle Cramps			Hallucinations		
Transfusion Reaction						Nervousness		
Blood Clots			**Females:** Are you Pregnant?					
Radiation Exposure			If so Last Cycle:					

Please List All Medications You Are Currently Taking-Include Prescriptions, Otc Meds And Herbal Supplements

Name Of Med	DOSE (Mg/Ml/Mcg)	HOW Often Do You Take It?

Please List True Allergies Only & Your Reaction To Each Allergy:

Allergies (What Are You Allergic To):	Reaction (What Happens):

To The Best Of My Knowledge, I Will Answer The Questions On These Forms Accurately. I Understand That Providing Incorrect Information Can Be Dangerous To My Health. I Understand That It Is My Responsibility To Inform The Doctor And Office Staff Of Any Changes In My Medical Status. Dr. Japera N. Levine DPM PLLC Offers Her Patients The Opportunity To Communicate By E-Mail. This Form Provides Information About The Risks Of E-Mail, Guidelines For E-Mail Communication And How We Will Use E-Mail Communication. It Also Will Be Used To Document Your Consent For Us To Communicate With You By E-Mail By Instructing You On How To Setup Your Patient Portal.

Patient/Parent/Guardian Signature: ______________________________

PERSON FILLING OUT DOCUMENT IF DIFFERENT FROM THE PATIENT: ______________________________

Consent For Photography, Videotaping, Or Other Imaging For Media/Educational Purposes

Patient's Name: ______________________________ Patient's Date Of Birth: ____________

Dr. Japera Levine Typically Takes Pictures Of Each Patient To Help Educate The Patient As Well As Other Patients' Who May Have A Similar Condition. Dr. Levine's Office Strictly Uses Pictures & Videos; We Will Keep Each Patient's Information Confidential. If You Agree Please Initial & Sign Below.
I Give My Consent To Have Photographs, Videotaped Images, Or Other Images Made Of **My Medical Condition & Myself.** I Understand And Agree That These Images May Be Used By Dr. Japera N. Levine DPM PLLC At **Any** Time For The Purpose (S) Outlined Below Without Compensation.

_____ Teaching Purposes (May Include Being Shown To Other Patients)

_____ Advertisements By Dr. Japera N. Levine DPM PLLC

_____ Placement On Dr. Japera N. Levine DPM PLLC'S Website- drjlevinedpm.com

_____ Placement On Dr. Japera N Levine DPM PLLC'S Office Social Media- FB: Dr. Japera N. Levine/
SC: Dr. JLevine/IG: Dr. JNLevine

_____ Continuing Medical Education Or Board Certification Examinations

______________________________ ____________
Signature Of Patient/Parent/Legal Guardian Date

E-Mail Consent/Agreement

Risks

Communication By E-Mail Has A Number Of Risks That Include, But Are Not Limited To, The Following:

- E-Mail Can Be Circulated, Forwarded, And Stored In Paper And Electronic Files.
- Backup Copies Of E-Mail May Exist Even After The Sender Or The Recipient Has Deleted His/hers Copy.
- E-Mail Can Be Received By Unintended Recipients.
- E-Mail Can Be Intercepted, Altered, Forwarded, Or Used Without Authorization Or Detection.
- E-Mail Senders Can Easily Type In The Wrong E-Mail Address.
- E-Mail Can Be Used To Introduce Viruses Into Computer Systems.

How We Will Use E-Mail

1) We Will E-Mail You Instructions To Set-Up Your Patient Portal.
2) We Will Limit E-Mail Correspondence To Established Patients Who Are Adults 18 Years Or Older, Or The Legal Representatives Of Established Patients.
3) We Will Use E-Mail To Communicate With You Only About Non-Sensitive And Non-Urgent Issues
4) All E-Mails To Or From You Will Be Made A Part Of Your Medical Record. You Will Have The Same Right Of Access To Such E-Mails As You Do To The Remainder Of Your Medical File.
5) Your E-Mail Messages May Be Forwarded To Another Office Staff Member As Necessary For Appropriate Handling.
6) We Will Not Disclose Your E-Mails To Researchers Or Others Unless Allowed By State Or Federal Law. Please Refer To Our Notice Of Privacy Practices For Information As To Permitted Uses Of Your Health Information And Your Rights Regarding Privacy Matters.

I May Want To Communicate With Dr. Japera N. Levine DPM, PLLC, And The Office Staff By E-Mail. I Understand The Risks Of Communicating By E-Mail, In Particular The Privacy Risks Explained In This Form. I Understand That Dr. Japera N. Levine DPM PLLC Cannot Guarantee The Security And Confidentiality Of E-Mail Communication. Dr. Japera Levine Will Not Be Responsible For Messages That Are Not Received Or Delivered Due To Technical Failure, Or For Disclosure Of Confidential Information Unless Caused By Intentional Misconduct.

I Understand That I May Also Communicate With Dr. Japera Levine DPM, PLLC By Telephone Or During A Scheduled Appointment, And That E-Mail Is Not A Substitute For Care That May Be Provided During An Office Visit. Appointments Should Be Made To Discuss Any New Issues Or Any Sensitive Medical Information.

I Understand That Either Dr. Japera N. Levine DPM PLLC Or I May Stop Using E-Mail As A Means Of Communication Upon My Written Request. My Revocation Of Consent Will Not Affect My Ability To Obtain Future Health Care Nor Will It Cause The Loss Of Any Benefits To Which I Am Otherwise Entitled.

I Have Read And Understand This Form. I Have Had The Opportunity To Ask Questions And My Questions Have Been Answered To My Satisfaction. I Understand And Agree With The Information Contained In This Form And Give My Consent For E-Mail Communications To And From Dr. Japera N. Levine DPM PLLC.

E-Mail: ______________________________________

Signature: ______________________________________ Date: ____________

Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of patient: ______________________________ Date of Birth: ______________________

This form is to authorize any person who is **NOT** the parent/guardian to be present with the patient for an office visit in the event the parent is not able to bring the patient in for their appointment.

By signing this document, you are giving the person listed below authorization to make medical decisions for your child in your absence.

To revoke authorization, a letter must written and new consent must be signed. The person authorized must present to office with a picture ID.

You may list more than one person, but any person not listed on this consent will be sent home without the patient being seen for their appointment.

Dr. Japera Levine is not responsible for any decisions made by the authorized personnel without the parent/guardian's knowledge.

Phone calls will not be permitted during the patient's visit in order for the parent/guardian to be contacted.

If you do not wish to authorize anyone other than the parent/legal guardian to bring the patient in for an appointment, please indicate that at the bottom of the page.

You can simply write, "Do not consent" in the blank space.

If you do not authorize anyone besides the parent/guardian to bring the patient in for his or her appointment, the parent/guardian must be present to each visit.

Any child under the age of 18 will **NOT** be seen without a parent/guardian/authorized person present.

Parent/Legal Guardian Name & Phone Number: ______________________________

Authorized Person Name & DOB: ______________________________

Phone Number: ______________________________

Relationship to Patient: ______________________________

Authorized Person Name & DOB: ______________________________

Phone Number: ______________________________

Relationship to Patient: ______________________________

Authorized Person Name & DOB: ______________________________

Phone Number: ______________________________

Relationship to Patient: ______________________________

Parent/Guardian Signature: ______________________________ Date: ______________

THIS FORM PERTAINS TO ANYONE UNDER THE AGE OF 18 ONLY

Patient's Financial Responsibility Policy

- Payment Is Due **At The Time Of Service-Without Exception**. We Will Accept Visa, MasterCard, Discover, Or Cash. We Do Not Accept Amex Or Check.

- Your Insurance Policy Is A Contract Between You And Your Insurance Company. It is your responsibility to know/understand your insurance benefits. As A Courtesy, We Will File Your Insurance Claim For You If You Assign The Benefits To The Doctor. If Your Insurance Company Does Not Pay The Practice Within A Reasonable Period, We Will Look To You For Payment.
    - **Copayments**: By Law We Must Collect Your Carrier Designated Copay At The Time Of Service.
    - **Referrals**: If Plan Requires A Referral From Your PCP It Is Your Responsibility To Obtain The Referral Or Assure That Your PCP's Office Has Obtained The Referral Prior To Your Appointment.
    - **Non-Plan Patients/Non Insured**: Payment Is Expected At Time Of Service.
    - **Medicare**: We Will Submit To Medicare For The Entire Medicare Allowed Amount. The Patient Will Be Responsible For The Deductible And The 20% Co-Insurance, Which Can Be Billed Directly To Secondary Insurance If You Have One.

- We Have Made Prior Arrangements With Certain Insurers And Other Health Plans To Accept An Assignment Of Benefits. We Will Bill Those Plans With Which We Have An Agreement And Will Only Require You To Pay The Co-Pay/Co-Insurance/Deductible At The Time Of Service Or Any Services That Are Deemed Not Medically Necessary Or Covered By Your Plan.

- All Health Plans Are Not The Same And Do Not Cover The Same Services. In The Event Your Health Plan Determines A Service To Be "Not Covered," Or You Do Not Have An Authorization, You Will Be Responsible For The Complete Charge. We Will Attempt To Verify Benefits For Some Specialized Services Or Referrals; However, You Remain Responsible For Charges To Any Service Rendered. Patients Are Encouraged To Contact Their Plans For Clarification Of Benefits Prior To Services Rendered.

- You Must Inform The Office Of All-Insurance Changes And Authorization/Referral Requirements Prior To Your Arrival. In The Event The Office Is Not Informed, You Will Be Responsible For Any Charges Denied.

- For Most Services Provided In The Hospital, We Will Bill Your Health Plan. Any Balance Due Is Your Responsibility.

- Past Due Accounts Are Subject To Collection Proceedings. All Costs Incurred Including, But Not Limited To, Collection Fees, Attorney Fees, And Court Fees Shall Be Your Responsibility In Addition To The Balance Due To This Office. Your Past Due Balance Will Be Collected At Your Next Office Visit Or Be Paid Within 30 Days Of The Statement Date; Whichever Comes First. There Is A Service Fee Of $35.00 For All Returned Checks. Your Insurance Company Does Not Cover This Fee.

- Treatments For Injuries/Accidents Related To "On-The-Job" Or Automobile Accidents Involving Attorneys Are Required To Be Paid In Cash. We Will Not File Your Insurance For These Visits.

- We Are Sorry To Inform You That **All Nail/Callus Trimming Is Not A Covered Service By Your Insurance Plan** And Results In A $75 Charge Up Front. Any Medicaid Patients Requiring Diabetic Foot Exams Will Have An Out Of Pocket Expense. In Addition, Medicaid Will Not Cover Any Wound Debridement.

Signature: ______________________________ Date: ________________

Print Name: ______________________________