GARY W. COCKRELL, D.P.M. **785 OLD HICKORY BLVD. SUITE 101 BRENTWOOD, TN 37027 (615) 370-8880**
1994 GALLATIN RD. NORTH, SUITE 310 MADISON, TN 37115 (615) 370-8880

Welcome to our office. As a new or established patient, you are important to us and we want you to feel important every time you call or walk into this office. Please take a few minutes to read and **complete** these forms. **This information is necessary for us to make sure your office record is complete and to minimize any misunderstandings that may occur due to incorrect or incomplete information. Please note: We will file your insurance for you. Please allow us to make a copy of your insurance card(s) so we will be sure to have the correct information. You will be responsible for any remaining balance after your insurance carrier pays our office. Co-pays, co-insurance and any collectable deductibles or non-covered supplies will be collected on date of service-unless prior arrangements have been made. Thank you.**

PATIENT INFORMATION: REASON FOR APPOINTMENT? _____ **REFFERRED BY?**_____

DATE _____/_____/_____ ***IS PATIENT RESPONSIBLE PARTY? □ YES □ NO IF NO, WHO?** _____

PATIENTS NAME: _____ **HOME PHONE #** (_____) _____

ADDRESS: _____ **CELL PHONE #** (_____) _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SS# / PATIENT ID #:** _____

Driver's License # _____ **State:** _____ **Email:**_____

PLEASE CHECK: □FEMALE □MALE FULL TIME STUDENT: □YES □NO NAME OF SCHOOL: _____

ARE YOU? □MARRIED □WIDOWED □SINGLE □MINOR □SEPARATED □DIVORCED □PARTNERED ARE YOU EMPLOYED? □ YES □ NO
Full Time: Y N Part Time: Y N

EMPLOYER NAME/COMPANY: _____ **PHONE #** (_____) _____

ADDRESS: _____ **CITY:** _____ **STATE:**_____ **ZIP CODE**_____

NAME OF INSURANCE CARRIER: _____

INSURANCE POLICY #: _____ **GROUP #:** _____

WHO IS THE PRIMARY SUBSCRIBER ON INSURANCE POLICY? □ SELF □ SPOUSE □ PARENT □ STEPPARENT □ OTHER

IMPORTANT: IF YOU ARE INSURED WITH SPOUSE / PARENT OR OTHER – PLEASE COMPLETE ALL THE BELOW QUESTIONS TO FILE YOUR INSURANCE CLAIM OR YOU MAY BE RESPONSIBLE FOR LATE CLAIM FILING FEES DUE TO INCOMPLETE INFORMATION.

PRIMARY SUBSCRIBER'S NAME_____ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE # (_____) _____

DATE OF BIRTH_____/_____/_____ AGE: _____ **SS/HID#** _____-_____-_____

SUBSCRIBER'S EMPLOYER: _____ **PHONE #** (_____) _____ Ext _____

ADDRESS: _____CITY: _____STATE: _____ ZIP CODE _____

IS THERE A SECOND INSURANCE PLAN? □ YES □ NO (IF YES, PLEASE COMPLETE BACK OF THIS FORM)
REQUIRED BY ALL MEDICARE PLANS:
***PRIMARY CARE PHYSICIAN:** _____**CITY**_____**STATE**_____
PCP PHONE# _____-_____-_____**SPECIALIST NAME:** _____**PHONE#** _____-_____-_____

SPECIALIST ADDRESS: _____**CITY**_____**STATE**_____
DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? □YES □NO
IF YES, WHO? _____ **RELATIONSHIP:**_____ **PHONE#**_____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY: NAME: _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____)_____ CELL PHONE: (_____) _____

***PLEASE SIGN BACK OF FORM FOR CONSENT TO TREATMENT AND FILING OF YOUR INSURANCE – ALSO ANY SECOND INS INFO TO BE COMPLETED**

***If yes*, to a second insurance please supply information below:**

SECONDARY INSURANCE INFORMATION: (COMPLETE ONLY IF APPLICABLE)

IS THIS INSURANCE IN YOUR NAME? ☐ YES ☐ NO

***If no*, WHOSE NAME: _____ RELATIONSHIP: _____**

INSURED'S DATE OF BIRTH: _____/_____/_____ (BIRTHDATE IS REQUIRED TO FILE INSURANCE CLAIM)

SOCIAL SECURITY NUMBER OF INSURED IS REQUIRED TO FILE INSURANCE CLAIM: _____

INSURANCE COMPANY NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE_____ ZIP _____

ID#_____ IS THIS A GROUP INSURANCE? ☐ **YES** ☐ **NO** GROUP # _____

GROUP/EMPLOYERS BUSINESS NAME: _____

PLEASE COMPLETE FOR FILING OF YOUR MEDICAL CLAIMS

ASSIGNMENT AND RELEASE FOR NON-MEDICARE PATIENTS (EXAMPLE: Blue Cross Blue Shield, United Health Care, Etc.)

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. GARY W. COCKRELL ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSILE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

X_____ _____ _____/_____/_____
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP (IF OTHER) DATE

MEDICARE PATIENTS ONLY SIGN BELOW

MEDICARE AUTHORIZATION ONLY (IF YOU ARE A MEDICARE PATIENT-PLEASE SIGN BELOW)

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. GARY W. COCKRELL FOR ANY SERVICES URNISHED ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF "OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF THE HFCA-1500 FORM, OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUMBITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

X_____ _____/_____/_____
BENEFICIARY SIGNATURE DATE

CONSENT FOR TREATMENT – SIGNATURE REQUIRED

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

XPatient's Signature or Guardian_____ Date: _____/_____/_____

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ CURRENT USE - TYPE _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

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: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

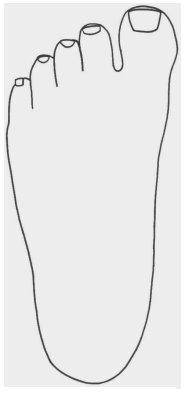
ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

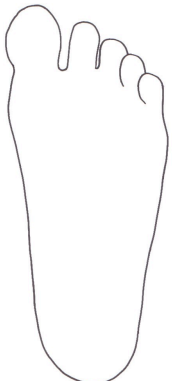
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT



TOP OF FOOT

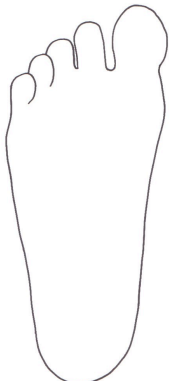


BOTTOM OF FOOT

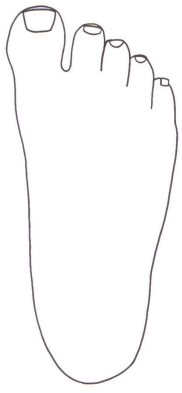
INSIDE OF FOOT

OUTSIDE OF FOOT

RIGHT FOOT

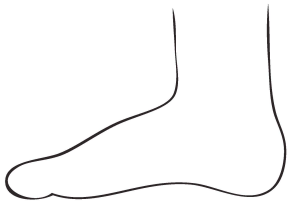


BOTTOM OF FOOT



TOP OF FOOT

OUTSIDE OF FOOT



INSIDE OF FOOT

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM 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.

_____ _____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN SIGNATURE OF DOCTOR

_____ _____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE

_____
DATE