Darren Silvester, *DPM, FACFAS, FABFAS, FAENS*
Gregory Larsen, *DPM, AENS*
Sara Grzywa, *DPM, AACFAS*

13525 Centerbrook, Suite 104
Universal City, TX 78148
210.375.3318

409 N. Bryant Street
Pleasanton, TX 78064
830.569.3338

www.NextStepFoot.com

Welcome to our practice!

We are happy you chose us for your foot care needs.

First, please take a moment to complete your **New Patient Intake forms**.

You will then be prompted to read through and sign our **Financial & Privacy Policy Agreement.**

In order to ensure a speedy intake process, please complete and submit

before your scheduled appointment date.

Thank you for taking the Next Step with us!

Next Step Foot & Ankle Clinic & Surgery

Darren Silvester, DPM, FACFAS, FABFAS, FAENS

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1. YOUR INFORMATION

Last Name: ____________ Legal First Name: ____________ Middle Name: ____________

DOB: ______ Age: ______ Shoe Size: ______ Gender: ○ Male ○ Female Weight: ______ Height: ______

Address: ____________ Apt #: ______ City: ______

State ______ Zip: ______ Email: ____________ Phone: ____________

How did you hear about us?
○ Friend/Family ○ Physician Referral ○ Website ○ Google Search (ie. Podiatrist near me)
○ Google Search (ie. A Specific Foot/Ankle Condition) ○ Email Blast ○ Blog ○ YouTube ○ Facebook
○ Instagram ○ Sign ○ Other

If Friend/Family, please provide FIRST and LAST name of patient so we can thank them: ____________

If other: ____________

WHY IS THIS SO IMPORTANT TO US? Sharing how you found us helps us know what avenues are working best to reach those in pain and in need for foot and ankle care. It allows us to allot our funds conservatively regarding outreaching those who need care and utilizing those funds to provide treatment options and technology other podiatrists are unable to due to cost. So, thank you from all of us at Next Step Foot & Ankle clinic for sharing. :)

Reason for your visit with us? ____________

Date occured: ____________

Tell us something personal? (Hobbies, interests, etc.) This will help us get to know you better. :)

____

2. EMERGENCY CONTACT INFORMATION

Name: ____________

Relationship: ____________

Contact Number: ____________

PCP or Referring Physician (Full Name): ____________

Where are they located? ____________

Contact Number: ____________

If Diabetic, Full Name of Diabetic Dr: ____________

Where are they located? ____________

Contact Number: ____________

When did you see them last? ____________

A1C Score: ____________

3. INSURANCE INFORMATION

Do you have insurance
○ Yes ○ No

Are you the:
○ Primary Insured ○ Dependent

Does the card say:
○ HMO ○ PPO ○ EPO

Is your Injury/Condition:
☐ Work Related

If other: ____________

Does it require a referral?
○ Yes ○ No

Primary Insurance Company: ____________

Group Number: ____________

Member ID / Policy #: ____________

Client Relationship to Insured:
○ Self ○ Spouse ○ Child ○ Other

Insured Name: ____________

Insured Phone #: ____________

Insured Date of Birth: ____________

Insured Gender:
○ Female ○ Male

Insured Street Address: ____________

Insured City: ____________

Insured State: ____________

Zip Code: ____________

If Tricare:

Sponsor Name: ______________________ Sponsor DOB: ______________________ Sponsor Social: ______________________

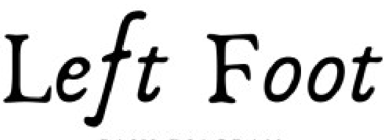
4. INSURANCE CARD Please attach your Insurance Card. (Front & Back) If you are filling this out via SMS, you can use your camera to take a picture and upload the FRONT & BACK of your card.

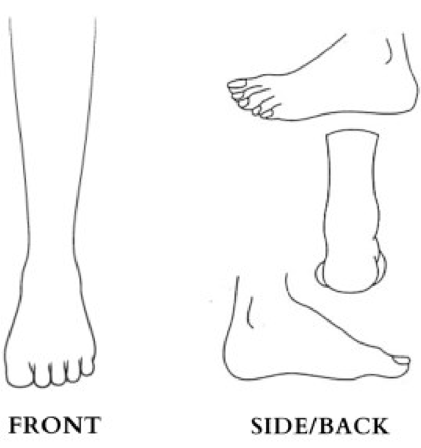
5. DRIVERS LICENSE Please attach your Drivers License. (Front & Back) If you are filling this out via SMS, you can use your camera to take a picture and upload the FRONT & BACK of your card.

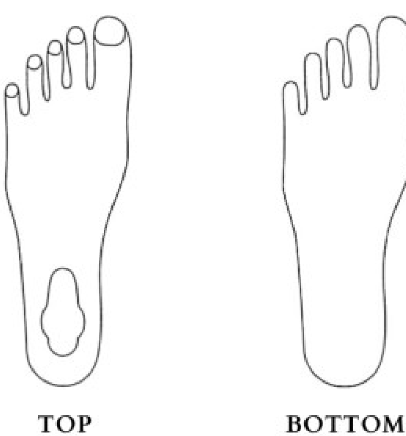
6. PATIENT PROFILE PORTRAIT (HEADSHOT) To help expedite your first appointment experience, you can upload your portrait/headshot HERE for us to use in our patient database system. If you are filling this out via your cellphone, you can use your camera to take a picture and upload it that way. (Please remove your hat, sunglasses, face mask, etc. that may block your face..i.e. let us see those wonderful faces and smiles)

7. CURRENT PROBLEMS Circle area(s) where the pain is in your LEFT FOOT: To indicate the pain level, change the color of the brush by selecting: Red - SEVERE | Green - MODERATE | Blue - MILD MOBILE USERS: Slide your finger upwards on the far left side of the image to scroll up.

0 - Severe 1 - Moderate 2 - Mild





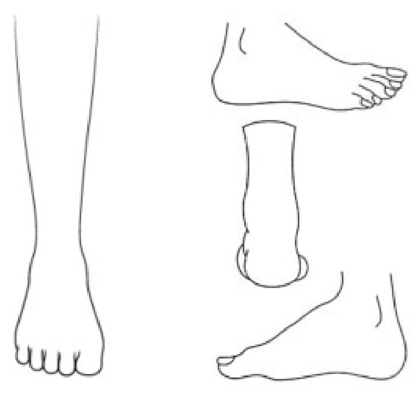


8. LEFT FOOT ISSUES

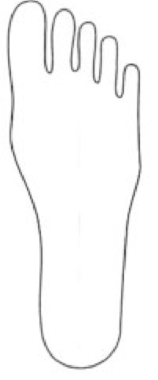
Pain Scale (1-10 | 10 being the worst):

____

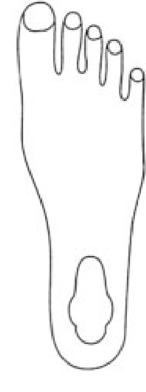
9. CURRENT PROBLEMS Circle area(s) where the pain is in your RIGHT FOOT: To indicate the pain level, change the color of the brush by selecting: Red - SEVERE | Green - MODERATE | Blue - MILD MOBILE USERS: Slide your finger upwards on the far left side of the image to scroll up.



FRONT SIDE/BACK



BOTTOM



TOP

10. RIGHT FOOT ISSUES

Pain Scale (1-10 | 10 being the worst):

____

11. OTHER CONCERNS (Please check all that apply)

- ☐ Falling _____________
- ☐ Poor Circulation _____________
- ☐ Fungus _____________
- ☐ Replace Orthotics _____________
- ☐ Ingrown Toenail _____________
- ☐ Other: _____________

12. MEDICATIONS (Please provide a list of medications, dosage & frequency at first appointment)

	Medication Name	Dosage	Frequency	Since When?

1				
2				
3				
4				

13. PHARMACY INFORMATION

Pharmacy: ______________________________

Street Address: ____________ Apt./Unit #: ______ City: ____________ State: ______ Zip Code: ______

Phone: ______________________ Fax: ______________________

14. ALLERGIES (Please check all that apply)

☐ None ______ ☐ Egg ______ ☐ Codeine ______

☐ Aspirin ______ ☐ Latex ______ ☐ Iodine ______

☐ Adhesive Tape ______ ☐ Local Anesthetic ______ ☐ General Anesthetic ______

☐ Sulfa ______ ☐ Oak ______ ☐ Shellfish ______

☐ Milk ______ ☐ Penicillin ______ ☐ Heparin ______

☐ Other: ______

15. DO YOU HAVE A (Please check all that apply)

Pacemaker
○ Yes ○ No

Back Stimulator
○ Yes ○ No

16. ATTESTATION I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsifications, omissions, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify NSFAC immediately of any changes to the above information and I will be asked to do an annual update to this registration form annually.

PRINTED PATIENT NAME OR LEGALLY AUTHORIZED REPRESENTATIVE: ______________________ DATE: ______

RELATIONSHIP TO PATIENT: (If Authorized Representative)

____

Signature of Patient or Legally Authorized Representative:

____ ________________

Signature Date