SCHOPPE
FOOT & ANKLE

PATIENT INFORMATION AND CONSENT (PLEASE PRINT LEGIBLY)

PHYSICIAN NAME _____ FACILITY CODE _____

PATIENT INFORMATION

DATE: _____ PATIENT SS# _____

PATIENT NAME: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Home Phone: ( ) _____ Cell: ( ) _____

Date of Birth: _____ MALE ☐ FEMALE ☐

Marital Status: MARRIED ☐ SINGLE ☐ Spouse's Name: _____

Driver's License # and State: _____

Employer Name: _____

EMERGENCY INFORMATION
In case of an emergency, contact:

Name: _____

Relationship: _____

Address: _____

Home Phone: ( ) _____

Cell: ( ) _____

GUARANTOR INFORMATION (If different from above)

Name: _____

Relationship: _____

Address: _____

Home Phone: ( ) _____

Work: ( ) _____

Employer: _____

PRIMARY CARE PHYSICIAN

Name: _____

Date of Last Exam: _____

REFERRAL SOURCE (circle/indicate one)

• Sign • Family • Insurance Book • School
• Family Doctor • Friend • Patient • Screening
• Newspaper • Yellow Pages
Website Other _____

FOR OFFICE USE ONLY

Deductible: _____ Remaining Ded: _____
Co-Pay: _____
Orthotics: _____ DME: _____ Date Verified: _____
Spoke With: _____

CONSENT ASSIGNMENT AND RELEASE

(I, the undersigned certify that I (or my dependent) have insured coverage with _____

and assign directly to SCHOPPE FOOT & ANKLE all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for costs not covered or reimbursed by third party payers. I hereby authorize the doctor to release all information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS, necessary to secure the payment of benefits to any responsible party. I authorize the use of this signature on all insurance submissions certifying that the information provided here is true and correct.

_____
Responsible Party Signature/Relationship to Patient /Date

CONSENT TO TREAT

I request and authorize the physician and his staff to provide me with treatment, and to perform any procedures now contemplated or such additional procedures the doctor may deem reasonable or necessary.
I authorize the Social Security Administration to disclose information regarding my Medicare coverage, including but not limited to, verification of my Medicare number, effective dates, and type of coverage.
I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) it and understand the notice. The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by that patient's general agent to execute the above, and accept its terms. It is further understood that this release remains in effect for one (1) year unless otherwise revoked.

_____ _____
Patient Signature Date Signature of Person Authorized to Sign in Lieu of Patient/ Relationship

MEDICAL HISTORY

SCHOPPE
FOOT & ANKLE

Patient name: _____

My foot problem is: _____

How long? _____

Prior or self-treatment for this problem: _____ How long? _____
Employment: ☐ Sit at job ☐ Stand and walk at job ☐ Retired ☐
Does employment require any particular type of shoes? (Check one) Boots ☐ Heels ☐ Other ☐

Circle/List any condition(s) in **Your History** or that **You** currently have:

Anemia	Diabetes **Yes or No**	Hepatitis	Low Back Problem	Stomach Ulcer
Asthma	Insulin **Yes or No**	High Blood Pressure	Phlebitis	Stroke
Arthritis	Epilepsy	Unequal Leg Strength	Poor Circulation	Tuberculosis
Blood Problem	Fainting Spells	Kidney Problems	Prone to Infection	HIV (AIDS)
Cancer	Gout	Leg Cramps	Shortness of Breath	Varicose Veins
	Heart Problem	Liver Problem	Sickle Cell Anemia	

Other: _____

Additional System Review (**Circle/List** any other condition(s) **You** currently have:

Fever	Bruise/Bleed Easily	Glaucoma	Stomach Problem
Nose/Sinus Problem	Chest Pain	Nervous Disorder	Weight Gain/Loss
Sore Throat	Muscle Pain	Anxiety	Skin Problem
Swallowing Difficulty	Nerve Pain	Mental/Emotional Problem	Ulcers/Skin Change
Ear/Hearing Difficulty	Neurological/ Muscular Problem	Lymph Gland Problem	Sores in Mouth
Allergies (Seasonal)	Migraine Headache	Thyroid Problem	Breast Lumps
Dizziness/Balance Difficulty	Poor Vision/Eye Problem	Hormone Problem	Blood in Urine
Fast/Slow Pulse	Eye Problem	"Gland" Problem	Urine/Kidney Problem

Other: _____

Circle **Yes** or **No** and complete the following information:

Do you drink caffeine? Yes or No If yes, amount: _____
Do you smoke? Yes or No If yes, amount: _____
Do you drink alcohol? Yes or No If yes, amount: _____
Do you take illegal drugs? Yes or No If yes, amount: _____
Do you take medications? Yes or No (include prescriptions, over the counter Medications, and vitamins)
If yes, include name and dosage: _____ _____ _____
_____ _____ _____
_____ _____ _____

Pharmacy and/or Drug Store: _____ Phone: ( ) _____

Circle **Yes** or **No** to report your **Family History** (blood relatives):

		RELATIVE:			RELATIVE:
Diabetes:	Yes or No	_____	Flat Feet:	Yes or No	_____
Cancer:	Yes or No	_____	Tuberculosis	Yes or No	_____
Bleeder:	Yes or No	_____	High Blood Pressure:	Yes or No	_____
Hepatitis:	Yes or No	_____	HIV (AIDS):	Yes or No	_____
Bunions:	Yes or No	_____	Stroke Problems Heart	Yes or No	_____
Hammertoes	Yes or No	_____	Circulation Problem Leg/Ft:	Yes or No	_____

Circle any **allergies** and complete the following information:

Adhesive/Tape	Anticoagulants	Codeine Novocain	Seafood	NO ALLERGIES
Antibiotics	Aspirin	Iodine/Betadine	Penicillin	Other _____

Do you have any problems taking aspirin or ibuprofen (Advil, Motrin)? Yes No

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Please list any significant **surgeries** you have had:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Please list any **hospitalizations** you have had within the last 5 years:

_____ Date: _____
_____ Date: _____

If female, could you be pregnant: Yes No
What is your height? _____ Weight: _____ Shoe Size: _____

Patient Signature: _____ Today's Date: _____