Michael A. Schwartzman, DPM

Patient Intake Form

Name: _____
Last, Name, First Name

PATIENT:

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Primary Phone: (_____) _____

Alt. Phone: (_____) _____
Circle one - cell phone, work phone, spouse phone

Soc Sec #_____

Sex: ☐ Male ☐ Female Birthdate: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Preferred Language: ☐ English ☐ Spanish

Other: _____

Race: ☐ White ☐ Black/African American ☐ Asian

☐ American Indian/Alaska Native ☐ Pacific Islander

Ethnicity: Hispanic or Latino ☐ Yes ☐ No

Preferred method for our office to communicate with you:
☐ Telephone ☐ Email

GUARDIAN/LEGAL REPRESENTATIVE

If you not financially responsible for payment for your services, please write the information for the responsible party below.

Name: _____

Address: _____
(Write "Same" if you live with the guardian/legal representative)

City: _____

State: _____ Zip: _____

Email: _____

Primary Phone: (_____) _____

Are you a student?

☐ No ☐ Full-time student ☐ Part-time student

INSURANCE:
Please provide us with your drivers license/state ID and all current insurance cards upon arriving for your visit.

Primary Insurance:_____

Primary Insurance ID #: _____

Primary Insurance Group #: _____

Are you the subscriber or dependent of subscriber?

☐ Subscriber ☐ Dependent

If Dependent, please write the subscriber information.

Name: _____

Address: _____
(Write "Same" if you live with the subscriber)

City: _____

State: _____ Zip: _____

Email: _____

Primary Phone: (_____) _____

Sex: ☐ Male ☐ Female Birthdate: _____

Patient's Relationship to Subscriber:

☐ Spouse ☐ Child ☐ Other: _____

Do you also have another medical insurance plan?

☐ Yes ☐ No If Yes: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I am covered by the above listed medical insurance and I agree to assign all benefits, if any, otherwise payable to me directly to the provider of care for services rendered to me. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the use of my signature on all insurance submissions.

The doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining verification of insurance eligibility, determining insurance benefits payable for services and for obtaining payment for services provided to me.

I understand that my insurance may only pay a portion of the fee for the services provided. I understand that there may be a co-payment required at the time of my visit and there may be a balance remaining (or co-insurance) for which I am personally responsible for paying. I understand that co-payments are due and must be paid at the time of my visit.

_____
Signature of person assigned with financial responsibility for patient.

_____
Print the name of the person assigned with financial responsibility for patient.

_____ _____
Date Relationship to Patient

Michael A. Schwartzman, DPM

Medical History Form 1

Name: _____
Last, Name, First Name

PRESENT ILLNESS OR INJURY

What is the reason (problem) for your visit to our office?

_____

_____

_____

_____

Who is your Primary Care Physician? (i.e internist)

_____

Have you seen this or any another physician regarding this problem?

☐ Yes ☐ No

If Yes, please list: Doctor: _____

Date last seen by this Doctor: _____

How were you referred to our practice?

☐ Another doctor ☐ Listed in your insurance guide

☐ Friend ☐ Family member ☐ Advertisement

Other (explain): _____

MEDICAL HISTORY

What is your current smoking status?

☐ Current every day smoker ☐ Current some day smoker

☐ Former smoker ☐ Never smoked

Please indicate which foot/ankle problems you now have or have had in the past:

☐ Ankle Pain
☐ Athlete's Foot
☐ Bunions
☐ Corns and Calluses
☐ Cramps in Feet /Legs
☐ Flat Feet
☐ Heel pain
☐ Ingrown Nails
☐ Numbness in Feet, Legs, Toes
☐ Plantar Warts
☐ Swelling in Feet, Legs, Toes
☐ Tired Feet

Have you been diagnosed with any of the following?

(you must indicate Yes or No)	Yes	No
Diabetes	☐	☐
Hypertension	☐	☐
Peripheral Vascular Disease	☐	☐
Onychomycosis	☐	☐
Plantar Fasciitis	☐	☐

Have you been prescribed foot orthotics? ☐ Yes ☐ No

If yes, do you still use them? ☐ Yes ☐ No

ALLERGIES

Please tell us of any allergies you have and potential reactions (i.e nausea, hives) when encountered:

☐ Aspirin: _____

☐ Codeine: _____

☐ Demerol: _____

☐ Iodine: _____

☐ Novocain: _____

☐ Penicillin: _____

☐ Sulfa: _____

Other: _____

☐ NONE

MEDICATIONS

Please list any medications you are currently taking. If you require more space or would like a list of common medications please ask our receptionist to provide one.

_____

_____

_____

_____

_____

SURGICAL / INJURY HISTORY

List the type of injury or surgery and date:

_____

_____

_____

_____

PHARMACY

What is your preferred pharmacy?

Name: _____

Location: _____

Michael A. Schwartzman, DPM

Medical History Form 2

Last, Name, First Name

PATIENT HISTORY

Please mark Yes or No to indicate you have/have not had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Rash	☐	☐
Allergies to Anesthetics	☐	☐	Eye Problems	☐	☐	Respiratory Disease	☐	☐
Allergies to Medicine or Drugs	☐	☐	Fainting	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Foot or Leg Cramps	☐	☐	Shortness of Breath	☐	☐
Angina	☐	☐	Gout	☐	☐	Sinus Problems	☐	☐
Arthritis	☐	☐	Headaches	☐	☐	Special Diet	☐	☐
Artificial Heart Valves or Joints	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Hemophilia	☐	☐	Swelling in Ankles, Feet	☐	☐
Back problems	☐	☐	Hepatitis or Jaundice	☐	☐	Swollen Neck Glands	☐	☐
Bleeding Disorders	☐	☐	High Blood Pressure	☐	☐	Tired Feet	☐	☐
Cancer	☐	☐	Kidney Problems	☐	☐	Tuberculosis	☐	☐
Chemical Dependency	☐	☐	Liver Disease	☐	☐	Ulcers	☐	☐
Chest Pain	☐	☐	Low Blood Pressure	☐	☐	Varicose Veins	☐	☐
Chronic Diarrhea	☐	☐	Neuropathy	☐	☐	Venereal Disease	☐	☐
Circulatory Problems	☐	☐	Phlebitis	☐	☐	Weight Loss, Unexpected	☐	☐
Diabetes	☐	☐	Psychiatric Care	☐	☐	Other: _____		
Ear Problems	☐	☐	Radiation Treatment	☐	☐	Other: _____		

Is there a history in your family of any of the conditions shown above? ☐ Yes ☐ No

If yes, please describe. Also indicate the relationship.

_____

_____

_____

_____

_____

☐ Are you now or have you been under another doctor's care for any reason in the last two years?

Yes ☐ No

If yes, for what reason? _____

_____

What is your shoe size? _____

What is your last known height? _____

What is your last known weight? _____

What is your last known Blood Pressure? _____

HIPPA PRIVACY - ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

With the enactment of the Health Insurance Portability and Accountability Act of 1996, Whiting Foot and Ankle recognizes that a patient has the right to have his or her health information kept private and secure.

_____(Print full legal name here: the "Patient" or Patient's Legal Representative) have been provided with the Notice of Privacy Policy (the "Policy") of this provider and have been offered a copy of such policy to keep for my records.

_____(Initial here) I hereby acknowledge that I have been provided with a copy of the Policy.

_____(Initial here) I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

_____(Initial here) Authorization to give Medical Information to:

_____ Name _____ Relationship

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____

Signature of patient, guarantor or responsible party

_____

Print name of person whose signature appears

_____ Date _____ Relationship to Patient