Patient Information and Consent (Please Print Legibly)

Physician Name: ______________________ Facility Code: __________

Name: ____________________________________ DOB: ____________ Today's Date: ____________

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** ____________________

E-mail: _________________________________ Spouse/Partner Name: ____________________________

Address: __________________________________ City: _____________ State: ______ Zip: _________

Home #: ______________________ Cell #: ______________________

Driver's License # and State: ____

Employer: __________________________________ Phone: ______________________

Primary Insurance: __________________________ **Secondary Insurance:** __________________________

EMERGENCY CONTACT INFORMATION:

Name: ____________________________________

Relationship: ______________________________

Address: __________________________________

Home Phone: _______________________________

Cell Phone: ________________________________

GUARANTOR INFORMATION (If different from above)

Name: ____________________________________

Relationship: ______________________________

Address: __________________________________

Home Phone: _______________________________

Cell Phone: ________________________________

PRIMARY CARE PHYSICIAN

Name: ____________________________________

Date of Last Exam: __________________________

REFERRAL SOURCE

☐ 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 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**

My foot problem is? ______________________________

How long? ______________________________

Prior or self-treatment for this problem: ☐ **Yes** ☐ **No** **How Long?** ______________

☐ **Employed** ☐ **Sit at Job** ☐ **Stand and Walk at Job** ☐ **Retired**

Does employment require any particular type of shoes? ☐ **Boots** ☐ **Heels** ☐ **Other**

List any conditions(s) in Your History or that You currently have: ☐ **Amenia** ☐ **Asthma** ☐ **Arthritis** ☐ **Blood Problem**

☐ **Cancer** ☐ **Diabetes (☐ Yes ☐ No)** ☐ **Insulin (☐ Yes, ☐ No)** ☐ **High blood pressure** ☐ **Cancer** ☐ **Hepatitis**

☐ **Epilepsy** ☐ **Fainting Spell** ☐ **Gout** ☐ **Heart Problems** ☐ **Stroke** ☐ **Lower Back Problem** ☐ **Stomach Ulcer** ☐ **Phlebitis**

☐ **Unequal Leg Strength** ☐ **Poor Circulation** ☐ **Leg Cramps** ☐ **HIV** ☐ **Tuberculosis** ☐ **Kidney Problems**

☐ **Prone to Infection** ☐ **Shortness of Breath** ☐ **Varicose Veins** ☐ **Liver Problem** ☐ **Sickle Cell Amenia**

Other: ______________________________

Do you smoke or history of smoking: ☐ **Yes** ☐ **No** **How many packs per day:** _______ **How long?** __________

Pharmacy Name: ______________________ **Pharmacy Phone:** ______________________

Pharmacy Address: ______________________ City, State, Zip: ______________________

Primary Care Physician: ______________________ Phone: ______________ Date Last Seen: ______________

Address: ______________________________

Referring Physician: ______________________ Phone: ______________ Date Last Seen: ______________

Address: ______________________________

Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other:

Names(s): ______________________________

Vital Signs: Height: __________ Weight: __________ Shoe Size: __________

Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: ______________________
Name: ______________________
Name: ______________________
Name: ______________________
Name: ______________________
Name: ______________________
Name: ______________________
Additional Notes: ______________________

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Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: ______________________
Name: ______________________
Name: ______________________
Name: ______________________
Name: ______________________
Name: ______________________
Name: ______________________
Additional Notes: ______________________

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PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: ______________________________ Date: ______________________ (Rev. 10/21)