SHEILA SCHULER, D.P.M.
WELCOME TO OUR OFFICE

Today's Date:_____

First:_____ **MI:**_____ **Last:**_____

Gender: ☐ Male ☐ Female **Race** _____ **Ethnicity** _____ **Language** _____

Date of Birth_____/_____/_____ **Age**_____**Social Security Number**_____-____-_____

E-mail Address:_____

Mailing Address:_____

City:_____ **State:**_____**Zip**:_____

Home Ph #: (_____)_____**Cell Ph #: (_____)**_____

Best place and time to reach you_____

Emergency Contact:_____ **Ph #:**(_____)_____

Pharmacy Name:_____**Pharmacy Number:(_____)**_____

Primary Care Physician:_____**Phone #:(**____)_____

Name of Doctor and/or Friend that referred you:_____

Have you ever been to a Podiatrist before? ☐ **Yes** ☐ **No**

Name_____ **Last Visit**_____

Reason for your visit today: _____

When did problem start? _____

Previous treatment for this condition? ☐ **Yes** ☐ **No**

Treatment by: _____**Date treated:** _____

Please list any treatments received for this condition:_____

_____

Please check any foot problems you now have or have had in the past:

☐ Ankle Pain
☐ Athlete's Foot
☐ Bunions
☐ Corns and Calluses
☐ Flat feet
☐ Foot or Leg Cramps
☐ Heel Pain
☐ Ingrown Toenails
☐ Plantar Warts
☐ Swelling in Ankles or Feet
☐ Tired Feet

►Vitals

Weight: _____Height: _____ Shoe Size:_____

CONSENT FOR TREATMENT

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 Beneficiary, Guardian or Personal Representative Date

_____ _____
Print Name of Beneficiary, Guardian or Personal Representative Relationship

Patient Name:_____ **Date:**_____

MEDICAL HISTORY

►Patient Medical History

Have you been diagnosed with any of the following? Please check all that apply. ☐ **None**

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Back Problems
☐ Blood Clots
☐ Cancer
☐ Chemical Dependency
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fibromyalgia
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Disease
☐ Hemophilia
☐ Hepatitis ☐ A ☐ B ☐ C
☐ High Blood Pressure
☐ HIV+/AIDS
☐ High Cholesterol
☐ Irregular Heartbeat
☐ Kidney Stones
☐ Kidney Disease
☐ Liver Disease
☐ Psychiatric Care
☐ Stomach Ulcers/Reflux
☐ Stroke
☐ Thyroid Disorder
☐ Tuberculosis
☐ Other_____

►Social History

Please answer the following:

Occupation: _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Use of Alcohol ☐ No ☐ Yes (If yes, how much?)_____

Use of Tobacco Never ☐ Former ☐ Current ☐ (how much?)_____

Use of Drugs ☐ No ☐ Yes (If yes, type/frequency)_____

►Allergies

☐ **None**
☐ Adhesive/tape
☐ Anticoagulant Therapy
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other:_____

►Family History

Has anyone in your family been diagnosed with any of the following? ☐ **None**

	Relationship		Relationship
☐ Arthritis	_____	☐ Heart disease	_____
☐ Cancer	_____	☐ High blood pressure	_____
☐ Diabetes	_____	☐ Stroke	_____

►Current Medications - Include prescriptions, over-the-counter medications and vitamins

☐ **None** or ☐ See Attached List

Name	Dose	Frequency	Name	Dose	Frequency

►Previous Surgeries ☐ **None** or Please list procedure and date performed:

_____

_____

Patient Name: _____ **Date:** _____

PRIMARY INSURANCE INFORMATION

_____

Insurance Company

_____ _____

Policy Holder's Name **Policy Holder's Date of Birth**

SECONDARY INSURANCE INFORMATION

_____

Insurance Company

_____ _____

Policy Holder's Name **Policy Holder's Date of Birth**

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____ and
Name of Insurance Company(ies)
assign directly to Dr. Schuler all insurance benefits, if any, otherwise payable to me for services rendered. 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 above-named doctor may use by health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____

Print Name of Beneficiary, Guardian or Personal Representative Relationship

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Schuler for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____

Print Name of Beneficiary, Guardian or Personal Representative Relationship

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____ Date _____

FINANCIAL RESPONSIBILITY FORM

Our office will file all charges to your insurance plan on your behalf. Patients are responsible for any co-payments or deductible amounts on the day services are provided.

Remaining balances left by your insurance plan are the patient's responsibility and are between you and your insurance plan.

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*If any overdue balance is not paid after 90 days, these amounts will be sent to a collection agency and you will be responsible for any and all collection fees allowed by law.

_____

Name

_____

Date