# 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

# Review of Systems

1. **Constitutional:**

Chills Fever Sweats Weight Loss(intentional, unintentional) NONE

2. **Head, Eyes, Ears, Nose and Throat:**

Do you wear: Contacts Dentures Eyeglasses NONE
Do you have: Cataracts Difficulty Swallowing Dizziness Double Vision Neck Pain
Nose Bleeds Ringing in Ears Sore Throat NONE

3. **Cardiovascular:**

Cardiovascular Surgery Chest Pain Congestive Heart Failure Heart Attack
Heart Murmur Leg Pain with Exercise Palpitations Swelling in Legs/ Ankles NONE

4. **Hematological/ Lymphatic (blood):**

Anemia Bleeding Abnormalities Lump in Groin or Armpit Lymphoma Swollen Glands NONE

5. **Respiratory:**

Asthma Bronchitis Cough Difficulty Breathing Pneumonia
Previous Pulmonary Disease Shortness of Breath TB (tuberculosis) Exposure or Treatment NONE

6. **Gastrointestinal:**

Acid Reflux Blood in Stool Constipation Decrease in Appetite Diarrhea
Hepatitis Nausea Stomach Ulcers Vomiting NONE

7. **Endocrine:**

Diabetes Kidney Disease Often Thirsty Often Urinating Pancreatitis
Prostate Problems Thyroid Disorder NONE

8. **Musculoskeletal:**

Arthralgia Broken Bones Bursitis Feeling Weak Joint Pain
Tendonitis Weakness of Limbs None

9. **Nervous System:**

Aphasia(loss of speech) Ataxia(loss of balance) Confusion Fainting Migraines
Nervous Disorders Neuropathy(loss of sensation) Seizures Speech Difficulties
Strokes NONE

10. **Integumentary:**

Change in Skin Color Cracking of the Skin Eczema Growth on Skin Hair Loss
Keloid Lesions Rash Recurrent Infections
Sensitivity to Sun Skin Ulcers NONE

11. **Psychiatric:**

Anxiety Depression Nervousness Tension NONE

***To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.***

Patient/ Guardian Signature:_____ Date:_____