

# SCHWARZENTRAUB FOOT CLINIC

Welcome To Our Office

Please write clearly and legibly

Patient's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Address: \_\_\_\_\_

Name of Husband/Wife/Parent if Minor: \_\_\_\_\_  
Employers: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Party Responsible for Account: \_\_\_\_\_  
Type Medical Insurance: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Who may we thank for referring you to this office: \_\_\_\_\_

*People expect to get old  
their teeth wear out and they get fillings and replacements;  
their eyes wear out and they wear glasses of all kinds;  
and their hearing wears out, and they get hearing aids.  
But somehow people never expect their feet to wear out,  
they are supposed to go on forever, and yet they work harder  
and under worse conditions than most everything.*

*Your podiatrist consider walking a priviledge;  
he is dedicated to keeping you walking in comfort.*

*This is our philosophy.*

I hereby give permission to Dr. Schwarzentraub or whomever he may designate to administer treatment and to perform treatment procedures as may be deemed necessary in the diagnosis and treatment of my foot condition

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

# SCHWARZENTRAUB FOOT CLINIC, PC

Sean Schwarzentraub, DPM  
ACFAS

Sean Harper, DPM  
ACFAS

## Insurance Assignment and Privacy Practices

### Insurance Assignment

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and/or supplemental insurance to: Schwarzentraub Foot Clinic, PC. This assignment will remain in effect until revoked by me, in writing. I understand that I am financially responsible for all charges whether paid by my insurance. I hereby authorize Schwarzentraub Foot Clinic, PC to release all information necessary to secure payment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Acknowledgment of Privacy Practices and Authorization

In alignment with our privacy practices (copy available upon request) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I hereby authorize Schwarzentraub Foot Clinic, PC to release necessary appointment, medical and/or financial information to the following person(s) only, then sign and date:

If you do not wish to release your information to anyone, please write NONE then sign and date.

Name	Relationship
_____	_____
_____	_____
_____	_____

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



# Schwarzentraub

FOOT CLINIC PC

## Health History Questionnaire

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

What is your - Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

List **ANY ALLERGIES** and significant side effects (i.e., hives, anaphylaxis)?

**What pharmacy do you use?** \_\_\_\_\_

**What brings you here today?** (Describe which foot/ankle, and the problem you are having)

**How long have you had this problem?**

\_\_\_\_ Days \_\_\_\_ Weeks \_\_\_\_ Months \_\_\_\_ Years

**When do you experience the problem?**

\_\_\_\_ Constant \_\_\_\_ Frequently \_\_\_\_ Occasionally \_\_\_\_ Rarely \_\_\_\_ Nighttime

**Are you a Diabetic?** \_\_Y\_\_N **Treating Doctor/Endocrinologist:** \_\_\_\_\_

**Most Recent A1C:** \_\_\_\_\_ **Are you on insulin:** \_\_Y\_\_N **Blood thinner:** \_\_Y\_\_N

Do you have a heart condition? \_\_Y\_\_N **Who is your cardiologist:** \_\_\_\_\_

**Medical History:** Please circle **any/all** of the following **you currently or have ever had:**

- |                     |                |                     |                     |
|---------------------|----------------|---------------------|---------------------|
| High blood pressure | Heart Problems | Bleeding Problems   | Blood Clots         |
| HIV/Hepatitis       | COPD           | Pneumonia/TB        | Asthma              |
| Dialysis            | Stroke         | Diabetes I or II    | Heart Attack        |
| Psoriasis           | Gout           | Kidney Failure      | Autoimmune Disorder |
| Thyroid Disorder    | Arthritis/RA   | Anesthesia Problems | Cancer              |
| Ulcers              | Sleep Apnea    | Fibromyalgia        | Back Surgery        |

Please list **all** medications you are currently taking (prescription and over the counter):

**I have a list to attach:** \_\_\_\_\_

Name of Medication	Dosage (mg/mcg/unit)	How Often?

**Continued On Back**

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**Any Other Serious Medical/Psychiatric Problems or Recent Hospitalizations?**

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**Family History (Mother, Father, Brother, Sister):**

Arthritis      Diabetes      Heart Problems      Anesthesia Problems  
Bleeding Problems      Blood Clots      Foot Problems

**Social History:**

Do you drink alcohol? \_\_\_\_ Yes \_\_\_\_ No – How much/How often: \_\_\_\_\_

Do you smoke/vape/dip: \_\_\_\_ Yes \_\_\_\_ No – Daily Quantity? \_\_\_\_\_ How long? \_\_\_\_\_

Are you a FORMER tobacco user? \_\_\_\_ Yes \_\_\_\_ No Product/how long: \_\_\_\_\_

Illicit Drug use: \_\_\_\_\_ Yes \_\_\_\_\_ No

**Please list any past surgeries and dates (i.e. bypass, stenting, bunion surgery, etc.):**

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**Review of Systems - Please circle any/all of the following you have experienced:**

**General:** Fever, Chills, Fatigue

**Chest:** Shortness of Breath, Chest Pain, Palpitations

**GI:** Nausea, Vomiting, Diarrhea, Constipation

**Blood:** Excessive Bleeding, Blood Clots, Excessive Thirst or Urination

**Musculoskeletal:** Back or Neck Pain, Muscle or Nerve Pain with Walking

**Skin:** Rash, Sores, Poor Healing

**Nerves:** Loss of Strength/Balance, Sciatica, Burning, Numbness, Tingling, Confusion

Signature: \_\_\_\_\_ Date: \_\_\_\_\_