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 Adress: _____

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: _____

4601 66th street Ste. A Lubbock, TX 79414Phone: (806)793-3668 Fax: (806) 792-6664

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

Any Other Serious Medical/Psychiatric Problems or Recent Hospitalizations?

_____

_____

_____

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.)**:**

_____

_____

_____

_____

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: _____

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____*0*_____*+*_____*+*_____*+*_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.