PATIENT INFORMATION

Dr. Patricia M. Schultz ~ Podiatrist ~ Foot Specialist
8920 Colesville Rd, Silver Spring MD, 20910
Phone: (301) 589-1066 Fax: (301) 589-1810

Todays Date: _____

Patient Name: _____
Last First Middle Initial

Address: _____
City State Zip

Tel No.# _____ Email:_____

Sex: ( )Female ( )Male ( )Single ( )Married ( )Partner ( )Divorced ( )Widowed

Date of Birth:_____ Occupation:_____

Employer:_____ Employer's Address:_____

Employer Phone:_____ Financial Responsible Person: _____

Emergency Contact: _____ Relation:_____ Phone:_____

Referred by:_____ Primary Physician:_____

eRX:
Dr. Schultz now sends prescriptions directly to pharmacies as electronic prescriptions (eRX). The pharmacy can be any of your choosing. Please provide your selected pharmacy's information below:

Pharmacy Name: _____ Phone: _____ Address:_____

Primary Insurance

Subscriber: _____

Name of Insured: _____

Insured Date of Birth: _____

Policy No. _____

Group Name/ No. _____

Employer: _____

Relation to Insured: □Self □ Spouse □ Other

Secondary Insurance

Subscriber: _____

Name of Insured: _____

Insured Date of Birth: _____

Policy No. _____

Group Name/ No. _____

Employer: _____

Relation to Insured: □Self □ Spouse □ Other

*I hereby authorize Dr. Patricia Schultz to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to Dr. Patricia Schultz. In the event that my insurance does not pay for my services, or if I am a self-pay patient, I understand and agree that I am responsible for my entire bill . I certify that I have reported my medical or related information for the insurance company to determine my insurance benefits. This authorization may be revoked by either my insurance company or myself at any time, but in any event may be renewed one year after the date of my signature.

_____ _____ _____
Printed Name Signature of Patient or Guardian Date

Medical History

___ Anemia
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joint Placement
___ Asthma
___ Blood Clots/ Phlebitis
___ Blood Thinners
___ Blood Transfusion
___ Blurry Vision
___ Breast Cancer
___ Broken Bones
___ Cancer
___ Chemotherapy
___ Chest Pain
___ COPD
___ Defibrillator
___ Depression
___ Diabetes
___ Insulin
___ Pills
___ Dialysis
___ Digestive Disorder
___ Fever or Chills
___ GERD
___ Glaucoma
___ Gout
___ Hay Fever
___ Headaches
___ Hearing loss
___ Heart Attack
___ Heart Disease
___ Hepatitis
___ High Blood Pressure
___ High Cholesterol
___ HIV/AIDS
___ Hypertension
___ Hypotension
___ Hepatitis
___ Hyperthyroidism
___ Hypothyroidism
___ Immunosuppression
___ Joint Aches
___ Kidney Disease
___ Leukemia
___ Lupus
___ Lymphoma
___ MRSA
___ MS
___ Muscle Weakness
___ Nervous Disorders
___ Pacemaker
___ Parkinson's
___ Poor Circulation
___ Problems Bleeding
___ Problems Healing
___ Problems Scarring
___ Radiation Therapy
___ Rheumatic Fever
___ Seizures
___ Sickle Cell
___ Stomach Ulcers
___ Stroke
___ Sciatica
___ TB
___ Thyroid Problems
___ Tuberculosis

Past Skin Conditions: ☐Basal Skin Cancer ☐Dry Skin ☐Eczema ☐Melanoma ☐Nail Problems ☐Poison Ivy ☐Precancerous moles ☐Psoriasis ☐Scaling ☐Skin cancer ☐Sweating

Allergies: ☐Penicillin ☐Iodine ☐Codeine ☐Asprin ☐Food ☐Latex ☐Sinuses ☐Sulpha ☐Sulfites ☐ Tape ☐Seasonal ☐Other ☐Local Anesthetics

Medications:

Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____
Medication: _____ **Dosage:** _____

Consent for Disclosure on Protected Health Information:

It is our policy to take every measure to protect the privacy of your health information; however, your protected health information may be used and disclosed in order for us to carry out treatment, payment, or health care operations. For our policies regarding the protection of your health care information, please refer to our Notice of Privacy Practice. It is your right to review the policies prior to signaling this consent. The terms in the Notice of Privacy Practice may with time, be revised, but a current notice will always be available in our office.

It is stated in our Notice of Privacy Practice, you have the right to restrict how we use your protected health information in order to carry out treatment, payment, or health care operations; however, we are not required to agree to these restrictions. If we do agree to these restrictions, the restriction will be binding on the provider.

You have the right to revoke this consent in writing to the extent that we may have already taken action before we received such a request.

*I acknowledge receipt of the Privacy Notice and consent to the disclosure of my health information for the purpose of treatment, payment, and health care operations.

_____ Printed Name
_____ Signature of Patient or Guardian
_____ Date