

Practice: _____

Today's Date: _____

Name: _____ DOB: _____ Chart Number: _____

Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Other #: _____

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

Secondary Insurance: _____ Are you the insured? Yes No

Insured Information

Subscriber Name: _____ Relationship to insured: Spouse Child Self Other

Phone #: _____ Sex: Male Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? Physician Internet Telephone book Family member Friend
 Other: _____

What is the reason for your visit today? _____

Result of accident or work injury? Yes No

How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: burning constant dull sharp shooting throbbing tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

Practice: _____

Today's Date: _____

Name: _____ **Chart #:** _____ **Date of birth:** _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

Race: Asian American Indian or Alaska Native Black or African American
 White Native Hawaiian or other Pacific Islander Declined to specify

Preferred Language: _____ Declined to specify

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ **City, State, Zip:** _____

Primary Care Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Referring Physician: _____ **Phone:** _____ **Date Last Seen:** _____

Address: _____

Privacy Information Preferences

Do you want to be exempt from public reporting? Yes No Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No Can we leave voicemail on machine? Yes No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? Yes No

If yes, please provide your e-mail address: _____

Who can we leave messages with? Wife Husband Daughter Son Other:
Name(s): _____

Smoking Status

Current Every Day Smoker, Current Status Unknown

Current Some Day Heavy Tobacco Unknown If Ever

Former Never Light Tobacco I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

Current Medications

No Known Medications I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

Allergies

No Known Allergies No Known Drug Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Use the back of this form if more room is needed

Last Flu Shot Date: _____ **Did you get a pneumococcal vaccination?** Yes No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. (Assignment of Benefits): I authorize payment of medical benefits to the practice named above. (Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPAA Privacy): I acknowledge that I received my HIPAA Privacy Practices Notice. (Medication History): I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____

Date: _____

History and Physical

Name: _____ DOB: _____ Chart Number: _____

Medical History:

<input type="checkbox"/> Liver	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Breathing issues
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Gout	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Stomach/bowel	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Neuropathy (specify) _____	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Arthritis (specify) _____	<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> Diabetes (type 1, type 2)	<input type="checkbox"/> HIV	<input type="checkbox"/> CVA	
<input type="checkbox"/> other (specify) _____	<input type="checkbox"/> Skin disorders	<input type="checkbox"/> Stroke			

Are you pregnant? Yes No Are you nursing? Yes No

Surgical History None Appendectomy C-Section Angioplasty Bypass Cataracts Cholecystectomy

Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? Yes No

If yes, please describe: _____

Do you have any artificial joints? Yes (where? _____) No Do you have an artificial heart valve? Yes No

Social History

Do you smoke? Yes No If yes how many packs per day? 1 2 3 4 5 For how long? _____

Do you drink alcohol? Yes, everyday (5-7 days/week) Yes, occasionally/socially No/Rarely

Substance abuse: Yes, I have a current substance abuse problem. Please specify: _____

Yes, I had a past substance abuse problem. Please specify: _____

No, I have never had a substance abuse problem

What is your occupation? _____ Does it involve mostly standing or sitting

Do you exercise regularly? No, I do not exercise regularly Yes, I do the following regular exercise: _____

Family History Is there any family history (blood relative) of: (Please indicate family member)

<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Bleeding disorders _____	<input type="checkbox"/> Emphysema _____
<input type="checkbox"/> Blood clot _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Neurological _____
<input type="checkbox"/> Circulation problems _____	<input type="checkbox"/> Strokes _____
<input type="checkbox"/> Other (specify): _____	

Review of Systems (Please check the box if you currently have any of these symptoms or check "NONE")

Cardiovascular	<input type="checkbox"/> leg pain when walking	<input type="checkbox"/> fever	<input type="checkbox"/> chest pain/pressure	<input type="checkbox"/> leg swelling	<input type="checkbox"/> cold hands/feet
	<input type="checkbox"/> fainting	<input type="checkbox"/> palpitations	<input type="checkbox"/> vascular disease	<input type="checkbox"/> valve problems	<input type="checkbox"/> NONE
Genitourinary	<input type="checkbox"/> blood in urine	<input type="checkbox"/> hesitancy	<input type="checkbox"/> incontinence	<input type="checkbox"/> increased urgency	
	<input type="checkbox"/> decreased frequency	<input type="checkbox"/> excessive urination	<input type="checkbox"/> kidney disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE
Gastrointestinal	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> heartburn	<input type="checkbox"/> blood in stool	<input type="checkbox"/> vomiting	<input type="checkbox"/> constipation
	<input type="checkbox"/> diarrhea	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/> decrease appetite	<input type="checkbox"/> increase appetite	<input type="checkbox"/> NONE
Integumentary	<input type="checkbox"/> athletes foot	<input type="checkbox"/> nail abnormalities	<input type="checkbox"/> keloids	<input type="checkbox"/> itchiness	<input type="checkbox"/> dry, scaly skin
					<input type="checkbox"/> NONE
Hematologic	<input type="checkbox"/> lower leg ulcers	<input type="checkbox"/> sickle cell disease	<input type="checkbox"/> anemia	<input type="checkbox"/> blood thinners	<input type="checkbox"/> clotting disorders
					<input type="checkbox"/> NONE
Neurological	<input type="checkbox"/> tingling	<input type="checkbox"/> weakness	<input type="checkbox"/> seizures	<input type="checkbox"/> numbness	<input type="checkbox"/> headaches
	<input type="checkbox"/> tremors	<input type="checkbox"/> paralysis			<input type="checkbox"/> NONE
Musculoskeletal	<input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> muscle pain	<input type="checkbox"/> neck pain
	<input type="checkbox"/> sciatica	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> joint pain	<input type="checkbox"/> joint instability	<input type="checkbox"/> arthritis
					<input type="checkbox"/> NONE
Respiratory	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> COPD	<input type="checkbox"/> coughing	<input type="checkbox"/> snoring
	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> emphysema			<input type="checkbox"/> NONE

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

Consent to Treat

1. I _____ (patient name) give permission for **Drs. Schorr and Feder** to give me medical treatment.

2. I allow **Drs. Schorr and Feder** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Drs. Schorr and Feder** will have to send my medical record information to my insurance company.
 - I must pay my share of the costs.
 - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
-
3. I understand:
 - I have the right to refuse any procedure or treatment.
 - I have the right to discuss all medical treatments with my provider.

Patient's Signature

Date

Parent or Guardian Signature
(for children under 18)

Date

Print name

PATIENT CONFIDENTIALITY

In this office, Patient Confidentiality is a prime concern. Please indicate below with whom our office can or cannot leave a message.

Please check where appropriate.

	YES	NO	DOESN'T APPLY
Spouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Answering Machine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are you able to receive calls at your workplace? YES NO

May we call you at your workplace and state who is calling? YES NO

Due to confidentiality regulations, should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation.

	YES	NO	DOESN'T APPLY
Spouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Parent, Children and/or Significant Others

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Signature: _____ Date: _____

Podiatry Associates of the Palm Beaches

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Diplomate of the American
Board of Podiatric Surgery

Richard S. Schorr, D.P.M.
Diplomate of the American
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Suite 205
Loxahatchee, FL 33470

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2401 Frist Blvd.
Fort Pierce Medical Park
Suite 1
Fort Pierce, FL 34950

HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent, in writing, at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by:

PRINTED NAME – PATIENT OR REPRESENTATIVE

SIGNATURE

____/____/_____
DATE

RELATIONSHIP TO PATIENT (IF OTHER THAN PATIENT)

Witness:

PRINTED NAME – PRACTICE REPRESENTATIVE

SIGNATURE

____/____/_____
DATE

STATEMENT OF FINANCIAL RESPONSIBILITY

I _____ understand that services provided to me by Dr. Schorr, Dr. Feder are my responsibility to pay.

Insurance is a contract between my insurance company and myself; Dr. Schorr, Dr. Feder, are only a third party to this arrangement. I understand that as a courtesy, Dr. Schorr, Dr. Feder, will file claims for me. If payment is denied, suspended, below community standards, or is not provided DIRECTLY to us within 45 days of the date of treatment, I am responsible for immediate payment in full on my account. I understand that payment is due upon receipt of any billing statements from the office. I understand that it is my responsibility to verify that my account is current. My account will be considered past due if it is not paid in full within 15 days of the closing date listed on the billing statement..

Patients who are covered under an HMO plan are only responsible for any applicable co-payments or non-covered services. You will be notified prior to any non-covered services being rendered. Patients who are not covered under an insurance plan are responsible for payment in full at the time that the services are rendered.

Payments may be made with any valid Visa, Mastercard, American Express or Discover card. We also will accept local checks with a current drivers license, money orders, cashiers' checks or cash. A bank charge plus the amount of the check will be assessed for any returned checks.

I understand the failure to comply with the above will result in my account being sent over to a collections agency. I understand that I will assume all collection fees associated with the collection of my unpaid balance, in addition to my balance. I also understand that these measures are necessary, they may damage my personal credit rating.

By signing below, I am attesting to my understanding of my financial responsibility to this office for services rendered.

X _____

Signature of patient, Parent, or Gaurdian

X _____ Date _____