

Dr Michael A. Schumacher Registration Form

| | | | | | | | | |
|---|----------------|--|---------------------------------|--------------------------------|--------------------------------|--|-------------|-----|
| Today's date: | | | | PCP: | | | | |
| PATIENT INFORMATION | | | | | | | | |
| Patient's last name: | | First: | | Middle: | | Marital status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> DP | | |
| Is this your legal name? <input type="checkbox"/> Y <input type="checkbox"/> N | (Former name): | | | Birth date: / / | | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | | |
| Street address: | | | Social Security no.: | | | Home phone no.: | | |
| Pager: | | Cell: | | City: | State: | ZIP Code: | | |
| Referring Dr Name: | | Referring Dr Tel #: | | | Employer phone no.: | | | |
| INSURANCE INFORMATION | | | | | | | | |
| Insured Name: | | DOB: / / | Address: | | | City | St | Zip |
| Is this person a patient here? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Home phone no.: | | | Cell # | | |
| Occupation: | Employer: | | Employer Address: | | | Employer Tel: | | |
| Is this patient covered by insurance? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Primary insurance Name: | | | | | | | | |
| Primary Insurance Tel # | | | Policy # | | Group # | | Copay: | |
| Name of secondary insurance (if applicable): | | Subscriber's name: | | | Group no.: | | Policy no.: | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | | | |
| IN CASE OF EMERGENCY | | | | | | | | |
| Name of local friend or relative: | | | Relationship to patient: | | Home phone no.: | Work phone no.: | | |
| | | | | | () | () | | |
| <p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr Michael A. Schumacher or insurance company to release any information required to process my claims.</p> | | | | | | | | |
| Patient Signature: | | | | | | Date: | | |

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

| | | | | |
|---|--|-----------------------------|----------------------------|-------------|
| Name <small>(Last, First, M.I.):</small> | | <input type="checkbox"/> M | <input type="checkbox"/> F | DOB: |
| Marital status: | <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | Date: | | |
| Referring doctor: | PCP: | How did you find us? | | |

PERSONAL HEALTH HISTORY

| | | | |
|--------------------------------|------------------------------------|--|-------------------------------------|
| Why are you here today? | | How long: | |
| | | Which Foot <input type="checkbox"/> R <input type="checkbox"/> L or Both | |
| Check All that Apply | <input type="checkbox"/> Corns | <input type="checkbox"/> Ingrown Nail | <input type="checkbox"/> Fungus |
| | <input type="checkbox"/> Sprain | <input type="checkbox"/> Warts | <input type="checkbox"/> Arches |
| | <input type="checkbox"/> Trauma | <input type="checkbox"/> Bunion | <input type="checkbox"/> Hammer Toe |
| | <input type="checkbox"/> Infection | <input type="checkbox"/> Pain Walking | <input type="checkbox"/> Heel Pain |
| | <input type="checkbox"/> Fractures | <input type="checkbox"/> Other: | |

Medical History: Please *Write in where Applicable*

| | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> STD |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Drug allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Blood Clotting Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Tremors | <input type="checkbox"/> Persistent itch |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

| Surgeries | | |
|-----------|--------|----------|
| Year | Reason | Hospital |
| | | |
| | | |
| | | |
| | | |
| | | |

| Current Medications: | Please Fill in Information | |
|-----------------------------|-----------------------------------|-----------------|
| Name the Drug | Strength | Family History: |
| | | |
| | | |
| | | |
| | | |

| Allergies to Medications Please List Below | | <input type="checkbox"/> No Known Allergies |
|---|----------------------------------|---|
| Name Of Medications that caused Allergy | What Happened when it was taken? | |
| | | |
| | | |
| | | |

HEALTH HABITS AND PERSONAL SAFETY

| | | |
|------------------------------|--|---|
| Alcohol | Do you drink alcohol? <input type="checkbox"/> Yes: <input type="checkbox"/> No: | How often? |
| Tobacco: | Do you use Tobacco? <input type="checkbox"/> Yes: <input type="checkbox"/> No: | How Much? |
| How far can you walk? | | Is the reason for your visit limiting your ability to walk? |

Physicians Signature: _____ **Date:** _____

**For the office of
Michael A. Schumacher, DPM**

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Guardian

Signature