

DR JOEL SCHANCUPP
PODIATRIST—FOOT AND ANKLE SPECIALIST
MEDICINE AND SURGERY OF THE FOOT AND ANKLE

PATIENT INFORMATION

WELCOME TO OUR OFFICE. WE ARE VERY PLEASED TO HAVE YOU WITH US. PLEASE ANSWER THESE QUESTIONS TO HELP US BECOME BETTER ACQUAINTED. IF YOU NEED HELP, PLEASE DO NOT HESITATE TO ASK. THANK YOU.

Name _____ Date of Birth _____ Age _____ M _____ F _____

Address _____ City _____ Zip Code _____

Phone Number Home _____ Work _____ Cell _____

Social Security Number _____

Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Name of Spouse, Parent, Guardian _____

Address if different than above _____

Your Occupation _____

Employer _____

Business Address _____

Telephone _____

Person Responsible for Bill _____ CoPay required at time of Service _____

How Do You Plan to Make Payment Cash _____ Check _____ Visa _____ MasterCard _____

HEALTH INSURANCE

Subscriber's Name _____ Social Security # _____ DOB _____

Insurance Company _____ Policy Number _____

Family Doctor _____ Date of Last Visit _____

Former Podiatrist _____ Date of Last Visit _____

Reason for today's visit?

Please Check answers

1. Are you in good health?.....YES _____ NO _____

2. Have you ever been treated for heart trouble, stroke, asthma, epilepsy, rheumatic fever, kidney or liver problems? If YES, check the ones.....~~NO~~YES _____ NO _____

3. Is there any personal or family history of Diabetes?.....YES _____ NO _____

4. Is there any personal or family history of gout?.....YES _____ NO _____

5. Do you have any bleeding problems or difficulty healing?.....YES _____ NO _____

6. Are you presently taking any medications or pills?.....YES _____ NO _____

7. Have you had any serious illnesses or operations?.....YES _____ NO _____

8. Are you allergic or have experienced side effects to any of the following?.....YES _____ NO _____

Penicillin _____ Antibiotics _____ Codeine _____ Demerol _____ Aspirin _____ Iodine _____ Adhesive Tape _____

Novocain or Local Anesthesia _____ Others (Please List) _____

Whom may we thank for referring you to our office? _____

Today's Date _____ Patient/Guardian Signature _____