Snyder-Stuart Podiatry Centers

Neil S. Snyder, DPM *Meredith B. Stuart, DPM*

PATIENT INFORMATION Please fill out these forms and bring them with you to your appointment.

Date: ____ / ____/ 20____ Birth date: _____/____/_____

Last Name: _____ First Name: _____ M. Initial: _____

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

Home Phone: (_____) _____-_____ Cell/Work: (_____) _____-_____ Sex: M F (Circle One)

Email Address: _____ May we contact you by email? ____Yes ____No

Ethnicity: (Check One) ____ Hispanic ____ Non-Hispanic ____ Decline

Race: (Check One) ____ American Indian ____ Asian ____ African American
____ Alaskan Native ____ Pacific Islander ____ Caucasian

I request that all communications to me (by telephone, mail, email or otherwise by all physicians and staff of Snyder-Stuart Podiatry be handled in the following manner:

● Please send all written communications to Home or Email (Circle One) address.

● Please contact me by telephone at (_____) _____-_____ May we leave a message? (Circle One) Yes No

Marital Status: (check one) ____ Minor ____ Single ____ Married ____ Long-Term Partner _____ Divorced
_____ Widowed _____Separated

Employer: _____ Occupation: _____

How did you hear about Snyder-Stuart Podiatry? _____

In case of emergency, who should we contact? _____ Phone: (_____) _____-_____

PRIMARY INSURANCE

Person Responsible for Account:

Last Name: _____ First Name: _____ M. Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____
Responsible Party Employed By: _____
Business Address: _____ City: _____State: _____Zip: _____
Insurance Company: _____
Subscriber ID: _____ Group #: _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Last Name: _____ First Name: _____ M. Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ Responsible Party Employed By: _____
Business Address: _____ City: _____State: _____Zip: _____
Insurance Company: _____
Subscriber ID: _____ Group #: _____

ASSIGNMENT AND RELEASE

I hereby authorize payment to Dr. Neil Snyder / Dr. Meredith Stuart for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the Dr. Neil Snyder / Dr. Meredith Stuart and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: ____/_____/_____

REASON FOR VISIT

Please list your present health concerns, problems, or symptoms related to your foot/feet:

_____

_____

_____

_____

MEDICAL HISTORY

Physician's Name: _____ Phone: (_____) _____-_____

Date of your last Physical Exam: _____/_____/_____ Date of last Office Visit: _____/_____/_____

1. Are you currently under medical treatment? Yes or No
   If yes, please describe: _____

2. Have you ever had any serious illnesses or operations? Yes or No
   If yes, please describe: _____

   Any additional hospitalizations other than for surgeries listed: _____

   _____

3. Are you currently taking any medications, including over the counter medications? Yes or No
   If yes, please describe: _____

4. Do you smoke? Yes or No
   If yes, please describe: _____

5. Do you use alcohol? Yes or No
   If yes, please describe: _____

6. Do you use cocaine or other drugs? Yes or No
   If yes, please describe: _____

7. Have you had any allergic reactions to the following: (Please circle all that apply)

Local Anesthetics	Adhesive Tape	Sedatives	Iodine
Penicillin or other antibiotics	Anticoagulant Therapy	Aspirin	Codeine
Sulfa Drugs	Barbiturates (Sleeping pills)	Demerol	Novocain
Seafood	Any Other Known Allergies: Please describe: _____		

   Please describe any reactions to the above circled allergies: _____

   _____

8. Women Only: Are you taking birth control pills: Yes or No

Please mark "Yes" or "No" to indicate if you have ever had any of the following:

	Yes	No		Yes	No		Yes	No
Anemia (low blood count)			Gout			Pneumonia		
Angina			Glaucoma			Polio		
Anorexia (no appetite)			Heart Murmur			Prostate Problem		
Arthritis			Heart Disease			Psychiatric Care		
Artificial Valves/Joints			Hepatitis-Type _____			Rash		
Asthma			Hernia			Respiratory Disease		
Back Problems			Herpes			Rheumatic Fever		
Bleeding Disorders			High Blood Pressure			Scarlet Fever		
Blood Disease			HIV/AIDS			Shortness of Breath		
Cancer			Jaundice			Sinus Trouble		
Chemical Dependency			Kidney Problems			Skin Rash		
Chemotherapy			Latex Sensitivity			Stroke		
Chicken Pox			Liver Disease			Thyroid Problems		
Cholesterol-elevated			Low Blood Pressure			Tonsillitis		
Chronic Fatigue			Measles			Tuberculosis		
Circulatory Problems			Migraine Headaches			Ulcer		
Congenital Heart Lesions			Mitral Valve Prolapse			Venereal Disease		
Cough (persistent or bloody)			Mumps			Any other condition		
Diabetes			Multiple Sclerosis			Describe: _____		
Emphysema			Nervous Problems			_____		
Epilepsy			Pacemaker			_____		
Fainting			Phlebitis			_____		
Foot or Leg Cramps						_____		

CONSENT

I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

I understand that I MUST call and cancel any appointment that I am unable to attend. In the result of missing an appointment that is not cancelled I will be assessed a $25.00 fee. This fee must be paid before I can see the physician for another visit.

I understand that any balance on my account that is not paid within 90 days will be sent to collections and assessed a $25.00 past due fee. If this occurs, the total balance must be paid prior to scheduling another appointment with the physician.

Signature of Responsible Party: _____ Date: _____/_____/_____