

PATIENT INFORMATION

Todays Date: 04-24-20

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

Patient Name: Amrout, Sarah

iddle Initial

Address: _____

City

7in

Home: _____ Cell: _____ Email: _____

Notification Preference: Phone SS#: _____

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

Date of Birth: 09/09/1980 Occupation: _____

Employer: _____ Employer's Address: _____

Employer Phone: _____ Financial Responsible Person: _____

Emergency Contact: Relation: Phone:

Referred by: _____ Primary Physician: _____

eRX:

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

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

Past Skin Conditions:

- | | | | | |
|--|---|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Basal Skin Cancer | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Eczema | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Nail |
| <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Precancerous moles | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Scaling | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Problems | | | <input type="checkbox"/> Sweating | |

Allergies:

- | | | | | | |
|-------------------------------------|---------------------------------|-----------------------------------|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Food | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Sinuses | <input type="checkbox"/> Sulpha | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Tape | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Other |
| | | | | | <input type="checkbox"/> Local Anesthetics |

Medications:

Medication: _____

Medication: _____

Medication: _____

Medication: _____

Medication: _____

Medication: _____

Dosage: _____

Dosage: _____

Dosage: _____

Dosage: _____

Dosage: _____

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