GREEN FOOT & ANKLE CARE
W JOSEPH SCHOEPPNER, DPM
PATIENT UPDATE

Patient Name ______________________________________ Preferred Name __________________

Home Phone(____)_____________ Work Phone(____)____________ Cell Phone(____)__________

Address ____
STREET CITY STATE ZIP

SSN _________-_________-_________ Email Address ______________________________________

Birth Date ____/____/____ Sex: Male Female Marital Status: Married Widowed Single Divorced

Race: White African American Other ________ Ethnicity: Hispanic Not Hispanic Primary Language: __________

Occupation ____

Employer ____

Address ____
STREET CITY STATE

Spouse Name____ Birth Date____/____/____
Employer____
SSN _____-_____-_____Work Phone (____)_______________Cell Phone (____)________________

FILL OUT ONLY IF PATIENT IS A MINOR

Mother Name___________________________
Birth Date ____/____/____
SSN __________________________________
Work Phone (____)______________________
Cell Phone (____)______________________
Employer _______________________________

Father Name________________________________
Birth Date ____/____/____
SSN_______________________________________
Work Phone(____)____________________________
Cell Phone (____)___________________________
Employer___________________________________

Emergency Contact: __________________________________ Relationship __________________
Home Phone(____)___________ Work Phone(____)___________ Cell Phone(____)____________

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD(S) & DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY

Primary Insurance: ______________________________
ID #:____
Group #:____
Subscriber Name: ________________________________
Subscriber DOB: _________________________________

Secondary Insurance: _____________________________
ID #: ____
Group #: _______________________________________
Subscriber Name: ________________________________
Subscriber DOB: _________________________________

CONSENT FOR TREATMENT

Must be signed by all patients or guardians prior to being seen by physician

I certify that the information is true and correct to the best of my knowledge. I give my permission to the doctor to examine, photograph, x-ray, administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and/or ankle problems.

____ ____________________ ____________
Signature of Patient, Parent, Guardian or Personal Representative Relationship Date

MEDICAL HISTORY

Please fill out all blanks, use N/A if question does not apply

Patient Name ____ Birth Date _____/_____/_____

Are you pregnant? _________ Shoe Size _________ Weight _________ Height _________

Past Medical History – Please circle those that apply

AIDS/HIV	Cancer	High Blood Pressure	Shortness of Breath
Anemia	Chemical Dependency	History of Chemotherapy	Sinus Problems
Angina	Circulatory Problems	Kidney Problems	Stroke
Arthritis	Diabetes	Liver Disease	Swelling in Ankle/Foot
Artificial Heart Valves/Joints	Epilepsy/Seizures	Mitral Valve Prolapse	Thyroid Disease
Asthma	Fainting	Phlebitis	Transfusions of Blood
Back Problems	GI Ulcer/Bleeding	Pneumonia	Tuberculosis
Bleeding Disorder	Gout	Psychiatric Care	Ulcers
Blood Clots/DVT	Heartburn/Reflux	Respiratory Disease	Varicose Veins
Blood Thinners	Hemophilia	Rheumatic Fever	Weight Loss
Bronchitis	Hepatitis or Jaundice	Sexually Transmitted Disease	

Any other medical conditions not listed here ____

Allergies – Please circle those that apply

Adhesive/Tape	Demerol	Novocain	Anticoagulant Therapy	Eggs
Iodine	Penicillin	Aspirin	Anti-inflammatory Meds	Peanuts
Seafood	Codeine	Cortisone	Local Anesthetics	Glove Powder
Latex	Sulfa	Morphine	NSAIDS	Other ______________________

Current Medications (include over the counter medications and vitamins, or provide a list to copy)

____

____

Do you take oral contraceptives? Yes ___ No ___

Chief Complaint____

Is visit due to an accident? Yes ____ No ____

Family Doctor ____

Phone _______________________________________ Date Last Seen ______________________

Cardiologist ____

Phone _______________________________________ Date Last Seen ______________________

Endocrinologist ____

Phone _______________________________________ Date Last Seen ______________________

Preferred Pharmacy ____________________________________ Phone ___________________

DISCLOSURE AUTHORIZATION
ALL PATIENTS MUST COMPLETE

May we leave a message at your home or with other residents? Yes No

May we leave a message on your answering machine/voicemail? Yes No

Whom may we discuss your medical/financial information with?

Name ____ Relationship _________________

Home _______________________ Work _______________________ Cell _________________________