Dr. Jeffrey Schwalb & Dr. Chad Schwalb

Age_____ Date of Birth_____ □ Male □ Female (Mr.,Miss,Mrs.)

Patient_____

If minor, parent/legal
guardian_____

Patients Social Security #_____

□Married □Single □Divorced □Widowed □Separated

Residence
Address_____City_____Zip_____

Home
Phone_____AlternatePhone_____(Cell,Work,Other)

Employer_____Occupation_____

Employer's Address &
Phone_____

Name of Insurance
Company_____

Policy Holder: □ Self □ Spouse □ Parent

PLEASE READ BEFORE SIGNING

I hereby give permission to Dr. Jeffrey Schwalb or any designated person to examine and treat my feet medically, surgically, orthopedically, or physiotherapeutically and to photograph any information which the doctor deems necessary for his records.

Any x-rays, lab work, medications, appliances, or additional professional services will be billed to your insurance company. Payment is expected at the time services are rendered for patients without insurance.

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

_____

Printed name of signer and/or patient

_____ _____

Patient Signature/Authorized Signature – Relationship to Patient Date

Patients Name_____

Chief Complaint/Reason for Visit _____

Dr. Jeffrey Schwalb & Dr. Chad Schwalb

Patients Name_____

Chief Complaint/Reason for Visit _____

Referred By _____

Primary Care Physician_____ **Last Visit** _____

City _____ **Phone Number** _____

Pharmacy_____ **Location**_____

Endocrinologist_____

Drug Allergies_____

MEDICATIONS

Name Dose Frequency

SUPPLEMENTS

Name Dose Frequency

_____

_____

PAST SURGICAL HISTORY: (Operations, Trauma, Transfusions, Reactions to anesthesia)

_____

_____

SMOKING HISTORY

_____Current every day smoker # of packs_____

_____Current occasional smoker-amount/frequency

_____Former smoker _____Never smoked

Alcohol Use

Everyday Use-How Much_____

Occasional/Social_____

Recovering Alcoholic_____

Non-Drinker_____

General Medical/ Vital Information

Height_____ Weight_____ Shoe Size_____

PATIENT/FAMILY HISTORY: X for Patient, Circle for Family

Asthma	Diverticulitis	Hepatitis	Osteoporosis	Sickle cell
Bleeding	DVT	Hyperlipidemia	Pneumonia	Stroke
Bruising	Emphysema	Hypertension	PVD	Thyroid Disorder
Cancer	Gerd	IBS	RA	Tuberculosis
COPD	Gout	Kidney Disease	Rheumatic fever	Ulcer
Crohn's Disease	Heart Disease	MS	Seizure	Varicose
Diabetes	Heart Murmur	OA		

(**OFFICE USE ONLY**) **BP**_____/_____mm/hg **Sugar Well Controled** Yes___ No___ **HgbA1C**_____ **RBS**_____