

PATIENT INFORMATION

DR. HOWARD L. SCHULTHEISS, JR., D.P.M., P.A., ACCPPS
437 SOUTH MAIN STREET
BEL AIR, MD 21014

Welcome to my office. The following information is needed for proper billing and correspondence.

Should this information change, please notify the office. If you have any questions, or difficulty completing this form, please feel free to ask for help.

Name		Social Security #	
Address		Cell Phone #	
City	State	Zip	
Home Phone	Work Phone		
Date of Birth	Sex	M	F
Marital Status (circle one) S M W D Separated			
E-mail			
Patient's Employer		Position	
Spouse's Name		Work Phone	
Referred By			
PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)			
Name		Relationship	
Address			
Home Phone	Work Phone		
NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY			
Name		Relationship	
Address			
Home Phone	Work Phone		
AUTHORIZATIONS			
** You may request a detailed description of these authorizations from the receptionist**			
Benefits to Physician			
<input type="checkbox"/> YES <input type="checkbox"/> NO I hereby authorize payments directly to the physician of the medical/surgical benefits <input type="checkbox"/> YES <input type="checkbox"/> NO I also understand I am responsible for any portion of my bill not covered by my insurance. Patient balances are due in 30 days after which time interest will accrue at 1.5%. Accounts over 60 days with no payment arrangements will be sent to collections and have adverse affects on credit history. <input type="checkbox"/> YES <input type="checkbox"/> NO I hereby authorize release of information for insurance claim purposes. MIISSED APPOINTMENTS HURT YOU, THE DOCTOR AND SOMEONE IN NEED OF CARE. ALL MISSED APPOINTMENTS WITHOUT PRIOR NOTIFICATION WILL BE ASSESSED A \$35.00 CHARGE PER 15 MINUTES SCHEDULED. I understand all of the above and hereby state that the information is correct to the best of my knowledge.			
Signed			Date

For office use only:

Patient ID#: _____

MEDICAL HISTORY

DR. HOWARD L. SCHULTHEISS, JR., D.P.M., P.A., ACCPPS

Patient Name:	
Family Physician:	
Has he/she referred you to us?	
Former Podiatrist	
Why did you see your podiatrist?	
1. What problems bring you to our office?	
2. List all medicines you now use	
Your pharmacy name & phone number:	
3. Women: Are you pregnant?	If so, how many months?
4. Height	Weight

5. Indicate which of your immediate relatives have had any of the following diseases:

Arthritis		High Blood Pressure	
Bleeding disorder		Kidney disease	
Cancer		Mental/Emotional disease	
Diabetes		Neurological disorder	
Foot problems		Poor circulation	
Heart trouble		Stroke	

6. Do you have any artificial joints, implants, or stents? If yes, please explain _____

7. Please check "Yes" or "No" to indicate if you have had any of the following problems:

YES	NO	NATURE OF PROBLEM	COMMENTS AND GIVE APPROX. DATE
		Allergic reaction to medication	
		Allergic rhinitis/ hay fever	
		Anemia	
		Arthritis	
		Asthma	

For office use only:

Patient ID#: _____

YES	NO	NATURE OF PROBLEM	COMMENTS AND GIVE APPROX. DATE
		Back pain	
		Bladder problems	
		Bleeding tendency	
		Cancer	
		Chest pain / heart attack	
		Circulation problems	
		Cramps in feet or legs	
		Depression	
		Diabetes	
		Fainting or convulsions	
		Fibromyalgia	
		Frequent infections	
		Glaucoma	
		Gout	
		Headaches	
		Heart (CHF, bypass, etc.)	
		Healing problems	
		Hearing impaired	
		High blood pressure	
		HIV positive or carrier	
		Hormonal imbalance	
		Joint pain or stiffness	
		Kidney disease or stones	
		Leg ulcers	
		Liver/Gall bladder disease (jaundice)	
		Lung (pneumonia, TB, etc.)	
		Mitral valve prolapse/murmur	
		Multiple Sclerosis	
		Neurological disorder	
		Numbness in feet or legs	
		Osteoporosis	
		Other illness or problems	
		Pain in other areas	
		Parkinson's	
		Psychiatric care	
		Raynaud's disease	

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YES	NO	NATURE OF PROBLEM	COMMENTS AND GIVE APPROX. DATE
		Scarring tendency	
		Shortness of breath (Cough, Pleurisy, Wheezing)	
		Skin disorders	
		Stomach ulcers / GERD	
		Strokes	
		Swelling in feet or ankles	
		Thyroid	
		Varicose veins	
		Vision impairment	
		Weight loss	
		Do you smoke? How much?	
		Drink alcohol? How much?	
		Do you take drugs? How much? (Legal or illegal)	
		Do you exercise regularly?	
		Do you stand or sit at work?	
		Problems taking aspirin/Motrin?	

8. Please give details of any:

Surgeries/ Serious injuries	Approx. Date	Physician	Hospital

9. Have you previously had physical therapy? When? For what condition?

10. Is there anything you wish to tell your physician privately? Yes () No ()

For office use only:

Patient ID#: _____

11. I understand that honest and complete answers to each question asked in this medical history questionnaire are important to the provision of my medical care and I have answered them to the best of my ability. I assume all risks which occur as a result of my failure or refusal to disclose all medical information. I have been informed that if I am uncertain about any question on these forms I should ask the doctor or a member of the office staff for assistance.

Patient Signature _____ Date _____

Witness _____ Date _____

I would like to thank you for choosing my office for your foot care needs. My staff and I take pride in offering the highest quality service in a warm, friendly atmosphere. My philosophy is that communication and patient education are the cornerstones of successful treatment. The goal of the practice is to alleviate foot pain without surgery. In the event that surgery is necessary, our in-office, Medicare-approved, State licensed, ambulatory surgical center is prepared for your comfort and convenience.

***Thank you,
Dr. Howard Schultheiss, Jr., D.P.M., ACCPPS***

For office use only:
Patient ID # _____

Dr. Howard L. Schultheiss, Jr. DPM
437 South Main Street
Bel Air, Md. 21014
P: 410.836.0131 F: 410.836.8594

Acknowledgment of Notice of Privacy Practices

I understand I have certain rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I understand that this information can and will be used, without additional consent, for the following purposes:

- Treatment, including sharing the protected health information with providers and others involved in your treatment and follow-up, either directly or indirectly
- Payment
- Healthcare operations of this facility

I have been provided a copy of the Notice of Privacy Practices for this office. I understand the Notice of Privacy Practices contains a complete description of the uses and disclosures of my health information. I understand this office has the right to change its Notice of Privacy Practices at any time, and I may contact this office at the number listed above at any time and obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ Patient ID _____

Signature: _____

Date: _____

Relationship to patient (if minor): _____

Please identify anyone to whom personal data may not be released: _____

OFFICE USE ONLY

I attempted to obtain the patient's/responsible party's signature in acknowledgment of receipt of the Notice of Privacy Practices, but was unable to do so for the following reasons:

Date: _____ Reason: _____

Name of Office Staff: _____

Signature of Office Staff: _____