Steven R. Schwartz, DPM

Please complete this form and bring it, your insurance cards & a list of your current medications to your appointment.

Please arrive at _____ on _____ for your _____ appointment.

____ 810 Wayne Avenue, Chambersburg, PA 17201 ***(inside the Chambersburg Fitness Center)***

____ Fulton County Specialty Clinic 214 Peach Orchard Road, McConnellsburg, PA 17233

(P) 717 – 267 - 2892
(F) 717 – 267 - 3795

PATIENT REGISTRATION

Welcome to our office! So that we may serve you to the best of our ability, please complete this form as accurately as possible and return it to the receptionist.

Last Name _____ First Name _____ M _____

Address _____

City _____ State _____ Zip Code _____

Social Security # _____ Birthdate _____ Age ___ Email _____

Home Phone (___) _____ Cell Phone (___) _____

Marital Status _____ Emergency Contact _____ (___) _____

Employer Name _____

Employer Address _____

_____ Work Phone (___) _____

Occupation _____

Medical Doctor _____ Phone (____) _____

Address _____ Date Last Seen _____

Referred by _____ (example: Doctor/Patient/Insurance/Phonebook/Online/Sign)

Pharmacy (Name and City) _____

PLEASE NOTE THAT THE CENTERS FOR MEDICARE AND MEDICAID REQUIRE THAT WE ASK THE FOLLOWING QUESTIONS:

Preferred language: _____ Ethnicity: _____ Race: _____

PATIENT MEDICAL HISTORY

Date: _____

Patient Name: _____

Height: _____ Weight: _____ Shoe Size: _____

Describe the problem that you are having with your feet: _____ R L Both

How long have you had these symptoms? _____

Medications presently being taken?

Medication Name	Dosage	How Often *(Daily, Twice a day)*	Why do you take this drug Diagnosis / Illness

Supplements: (i.e. vitamins) 1). _____ 2). _____

Have You Ever Had:

	YES	NO		YES	NO
Arthritis			Gout		
Blood/Clot/Phlebitis			Heart Disease		
Cancer			High Blood Pressure		
Diabetes			Other: (Please list)		

List Allergies:

List Allergy	Type of Reaction	Location of Reaction	Severity of Reaction				Date, if known
			Very Mild	Mild	Moderate	Severe	

Are you currently pregnant? _____ If yes, please provide your due date: _____

Any Significant Medical Conditions in the family? Please list illness and relationship.

Illness	Relationship (Please state: mother, father, son, daughter, brother or sister)

Have you had any surgery? (please list) _____

_____

Tobacco Use: Never Smoked _____ Currently Smoke ____ Former Smoker: How long since you quit? _____

Primary Insurance Company _____

ID # _____ Group Number _____

Name of Policy Holder _____ Date of Birth of Policy Holder _____

Employer of Policy Holder _____

Secondary Insurance Company _____

ID # _____ Group Number _____

Name of Policy Holder _____ Date of Birth of Policy Holder _____

Employer of Policy Holder _____

Person financially responsible if other than patient:

Name: _____

Address: _____ Phone Number: _____

SIGNATURE ON FILE

- I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS
- I AUTHORIZE RELEASE OF PERTINENT INFORMATION TO ALL MY INSURANCE COMPANIES
- I ACKNOWLEDGE THAT ALL CHARGES INCURRD ARE MY RESPONSIBILITY REGARDLESS OF INSURANCE COVERAGE. (*Estimates of your costs can be provided however we cannot guarantee your insurance will provide this coverage. We must emphasize that as a medical provider our agreement is with you, not with your insurance company.* ***As the patient you are responsible for any balance not covered by the insurance company.***)
- I AUTHORIZE DR. STEVEN R. SCHWARTZ TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM INSURANCE COMPANIES
- I AUTHORIZE PAYMENT DIRECT TO DR. STEVEN R. SCHWARTZ
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

- I ACKNOWLEDGE THAT I WAS OFFERED/PROVIDED 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.

We Reserve The Right to Charge a $25.00 Fee For Appointments Missed Without 24 Hours Notice

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Patient Name (please print) _____ Date _____

Parent or Authorized Representative (if applicable) _____

Patient Signature _____

THANK YOU FOR CHOOSING OUR PRACTICE.