CENTER FOR FOOT AND ANKLE DISORDERS
1740 South Street • Suite 500 • Philadelphia, PA 19146
Telephone 215.546.1618 • Fax 215.546.9905
University of Pennsylvania Health System
Presbyterian Medical Center

Dr. Harold Schoenhaus, Dr. Edward Chairman, Dr. Richard Jay, Dr. Michael Troiano, and Dr. Patricia McIlrath

PATIENT NAME_____

Address_____

City_____ State_____ Zip code_____

Date of birth_____/___/____ Age_____ Gender/Pronouns _____

Marital Status_____ Social Security #_____

Home Telephone #(___)_____ Cell #(____)_____

Emergency Contact Name_____

Tel#(____)_____ Work #(____)_____

Email_____

Harold Schoenhaus, DPM
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Employer Information_____

Address_____ Tel #_____

City_____ State_____ Zip Code_____

Primary Insurance Co_____

City_____ State_____ Zip Code_____

Guarantor name_____

Date of Birth____/____/___ Social Security_____

Secondary Insurance co_____

Address_____

State_____ City_____ Zip Code_____

Tel #(___)_____

Primary Care Physician _____

Address_____

City_____ State_____ Zip Code_____

Who can we thank for referring you to this office?

Name _____

Telephone #(___)_____

Which pharmacy do you prefer us to escribe, call in, or send/mail your prescriptions to?

Name _____

Address_____

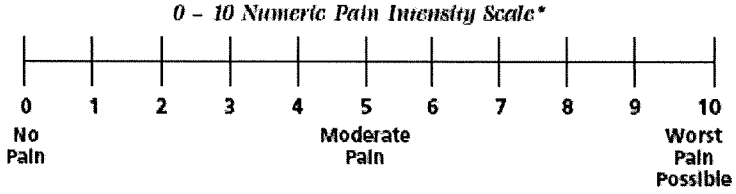
City_____ State _____ Zip Code _____

What is the problem that brought you in to see us today?

_____

_____

Please circle a number on the pain scale below if you are experiencing any pain at this time that pertains to your chief complaint.



Please check any of the following that pertain to you:

Anemia _____	Blood Pressure__	Epilepsy____
Arthritis _____	Heart_____	Phlebitis____
Poor Circulation___	HIV/ AIDS___	Edema____
Diabetes ____	Kidney Problems___	Gout_____
Difficulty Healing___	Leg Cramp_____	Other_____
Frequent infections___	Lung Disorders___	

Please list all medications you taking now

1._____

2._____
3._____

Have you been under the care of a doctor for the past two years?

Yes _____ No_____

If yes what for _____

Are you allergic to any medications? Yes_____ No_____

If yes please list_____

Please list any surgeries you have had in the past

_____

Any medical history you feel the doctor need to know please

List here_____

All information I have provided is correct and accurate

Patient signature_____ Date___/___/___

If you choose to email a doctor or employee of the practice, please be advised that we use commercial email addresses (MSN,Hotmail, aol, etc) and your privacy is subject to the commercial email company's security and we cannot guarantee your medical privacy as we do not control the security.

Patient signature _____ Date ___/___/___

Please be advised that we do not allow any video or audio recording of treatment visits or testing, as this is a violation of our office policy/HIPAA.

Patient signature _____ Date ___/___/___

Privacy Practice Notice

I request payment of authorized Medicare and /or other insurance benefits be made on my behalf to Dr.H.D.Schoenhaus P.C for any services furnished to me by physicians that is part of this practice.

I authorize any holder of medical information about me to be released to the health care financing administration and/or other insurance carriers and their agents of any information necessary to determine benefits and/or the benefits payable for related services.

I understand that I am responsible for any/all non-covered services, deductibles, and/or co-insurance not covered by my insurance carrier. I personally guarantee payment for such services and, in the event I fail to remit timely payment, authorize my attorney (if applicable) to deduct the payment from any proceeds, by settlement, judgment or otherwise, recovered on my behalf in connection with the events giving rise to the physician services I have received.

Patient signature_____ Date___/___/____

Attorney signature_____ _____ Date___/___/___

Office representative_____ _____ Date___/___/___

Dr.H.D Schoenhaus, PC

Receipt of notice of Privacy Practices
Written Acknowledgement Form

I,_____,have received a copy of notice of privacy practices.

Patient signature_____ Date___/___/_____

Patient representative_____ Date___/___/_____

Office representative_____ Date___/____/____