Foot CLinic of Oklahoma, PLLC
Dr. Angela Schuff, D.P.M.

Patient Information

Date:_____
SS# _____
Account #_____

Last Name: _____
First Name: _____ MI: _____

Address:_____
City: _____
State: _____ Zip:_____

Sex: ☐ M ☐ F Age:_____ DOB:_____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/School:_____

Guardian Employer:_____

Spouse Name:_____
DOB:_____ SS# _____
Spouse Employer: _____

Email:_____
Who referred you: _____
Family Physician:

Phone Numbers

Home Phone: (_____)_____
Cell Phone: (_____)_____
Work Phone: (_____)_____

In Case of an emergency, Contact
Name:_____
Relationship:_____
Home Phone: (_____)_____
Work Phone: (_____)_____

Pharmacy Name:_____
Pharmacy Number:

Insurance

Who is responsible for this account_____
Relationship to patient_____
Insurance CO._____
DOB_____ SS#_____
Is patient covered by additional insurance? ☐Yes ☐NO
Subscribers name:_____
Relationship to patient_____
Insurance CO._____
Group #_____

Insurance Agreement and Release
and
Privacy Act Notice

I hereby authorize Angela Schuff, D.P.M. and/or Foot Clinic of Oklahoma, PLLC to furnish information to my insurance carrier concerning my illness and treatments and hereby assign to Angela Schuff, D.P.M. and/or Foot Clinic of Oklahoma PLLC all payments for medical services rendered to myself or my dependents.
I hereby give my permission to Angela Schuff, D.P.M. and/or Foot Clinic of Oklahoma, PLLC to perform clinical and diagnostic examination procedures as maybe deemed necessary to diagnose and/or treat my foot/ankle condition.

This acknowledges I have received the Notice of Privacy Practices from my provider.

_____
Patients Signature

_____
Print Patients Name

Foot Clinic of Oklahoma, PLLC
Dr. Angela Schuff, D.P.M.

Name: _____ Date: _____

Podiatric History

What is the chief complaint
and how long has it been going on?
_____
_____
_____
_____
_____
_____
_____

Your Occupation_____
Athletic activities in which you
participate
(Please list and frequency)
_____
_____
_____
_____
_____

Cigarette/Tobacco use current_____ Quit_____
Packs/day_____ Years_____
Alcohol _____No _____Yes
_____Social _____Weekly _____Daily
Caffeine use/cups per day_____

Height _____ Weight_____
Shoe Size_____

Surgical History

_____
_____
_____
_____
_____
_____

Medical History

	SELF	FAMILY HISTORY		SELF	FAMILY HISTORY
AIDS/HIV	☐	☐	Liver Disease	☐	☐
Arthritis	☐	☐	Low Back Pain	☐	☐
Artificial Heart Valves	☐	☐	Neuroplathy	☐	☐
Artificial Joints	☐	☐	Osteoporosis	☐	☐
Asthma/COPD	☐	☐	Pacemaker	☐	☐
Bleeding Disorder	☐	☐	Reflux/GERD	☐	☐
On Blood Thinners	☐	☐	Seizures	☐	☐
Cancer	☐	☐	Sleep Apnea	☐	☐
Type:_____			Stroke	☐	☐
Diabetes	☐	☐	Thyroid Disease	☐	☐
Gout	☐	☐	Varicose Veins	☐	☐
Heart Disease	☐	☐	Nausea with anesthesia	☐	
Hepatitis	☐	☐			
High Blood Pressure	☐	☐			
Kidney Disease	☐	☐			

Other Mediacal Conditions:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Medications

Include Prescription, over-the-counter medications, and Vitamins with dosage
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

		Reaction
Adhesive Tape	_____ Yes	_____
Codeine	_____ Yes	_____
Contrast Dye	_____ Yes	_____
Demerol	_____ Yes	_____
Iodine	_____ Yes	_____
Latex	_____ Yes	_____
Local Anesthetics	_____ Yes	_____
Penicillin	_____ Yes	_____
Sulfa	_____ Yes	_____

Other_____
_____