Stahl Foot & Ankle

Date: ______________

Name: ____ SS# ____________________

First Middle Last

Age: ________ Birth date: ________________ Sex: M ____ F _____ Marital Status: S M D W

Address: ________________________________ City: ________________ State: ______ Zip: _______

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

May we leave a message on your answering machine? ☐ Yes ☐ No

May we leave a message with a family member? ☐ Yes ☐ No

Email address: ____ Ht: ______ Weight: __________

Are you currently a tobacco user? ☐ Yes ☐ No Shoe size & width: ________________

Employer: ________________________ Address: ____

Name of Spouse or Parent: ____________________________________ Relationship: ________________

Home Phone: ____________________ Alt. Phone: ____________________________

Address: ____

Emergency Contact: ____________________________________ Relationship: ________________

Home Phone: ____________________ Alt Phone: ____________________________

Address: ____

Family Physician: ________________________ Address: ______________________________

Physician's Phone : ________________________ Date Last Seen: ______________________

Pharmacy Name & Address: ____

Pharmacy Phone: ____________________ How Did You Hear About Our Office? ________________

What are you being seen for today:____

____

Dr. Brian Stahl, DPM | 2690 Kingston Road | Suite 103 | Easton, PA 18045 | Ph. 610.438.8899

Do you have any of the following problems on a regular basis:

_______ Recent Weight Loss	_______ Headaches	_______ Skin Rashes
_______ Fainting	_______ Abnormal Bleeding	_______ Back Pain
_______ Shortness of Breath	_______ Chest Pain	_______ Shoulder Pain
_______ Difficulty in Breathing	_______ Muscle weakness	_______ Hip Pain
_______ Nausea or vomiting	_______ Memory Loss	_______ Knee Pain
_______ Persistent Cough	_______ Painful urination	_______ Neck, arm or hand pain
_______ Swelling ankles	_______ Frequent urination	_______ Stomach pain

PAST MEDICAL HISTORY (please check)

_______ Diabetes	_______ Asthma	_______ Heart Disease	_______ High Blood Pressure
_______ Anemia	_______ Arthritis	_______ Epilepsy	_______ Bleeding Disorder
_______ Gout	_______ Stomach Ulcers	_______ Blood Clots	_______ Kidney Problems
_______ Liver Problems	_______ Tuberculosis	_______ Cancer	_______ High Cholesterol
_______ Lung Problems	_______ Thyroid	_______ Stroke	_______ Circulatory Problems
_______ Hepatitis	_______ HIV/AIDS	_______ Neuropathy	_______ Amputations
_______ Cramping in legs	_______ Foot Ulcers	_______ Other ____________________	

What MEDICATIONS do you take regularly? (Include prescriptions, over-the-counter medications and vitamins.)

____

____

____

Do you have any ALLERGIES to MEDICATIONS? Yes _____ No _______

If yes, what are they? ____

PAST SURGICAL HISTORY:

_____Appendix _____Hysterectomy _____Gallbladder _____Hip _____Abdominal/Bowel _______ Knee

_____Heart _____Tonsils _____Foot Surgery _____Veins/Arteries

Other ____

Please check any of the following diseases that run in your FAMILY. (M – mother, F – father)

_______ Diabetes _______ High Blood Pressure ________ Cancer _______ Arthritis _______ Heart Disease

INSURANCE

Who is responsible for this account? ___________________________ Relationship to patient: ______________________

Insurance Company: ____

Subscriber Name: ____ Relationship to patient: ______________________

Subscriber's Birth date: ______________________________ SS# ____

Member ID # ______________________________________ Group # ____

Is patient covered by additional insurance? ________ Yes ________ No

Insurance Company: ____

Subscriber Name: ____ Relationship to patient: ______________________

Subscriber's Birth date: ______________________________ SS# ____

Member ID # ______________________________________ Group # ____

FOR INSURANCE CLAIMS: I authorize the release of any medical information needed to process my claim and request claim assignment to be made directly to Stahl Foot and Ankle, LLC.

Signed:____ Date:________________

FOR MINORS: I as parent or guardian of the above named patient give my permission for Stahl Foot and Ankle, LLC to render medical and surgical treatment and will assume full financial obligation.

Signed:____ Date:________________

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES (HIPPA): I acknowledge that I have received a copy of Stahl Foot and Ankle's Notice of Privacy Practices. This notice describes how Stahl Foot and Ankle may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights I may have regarding my protected health information.

Signed:____ Date:________________

I hereby give my permission to Stahl Foot and Ankle, LLC to administer treatment; and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. I consent to the photographing of my foot condition.

Signed:____ Date:________________

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