

**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



Center for Foot and Ankle Disorders

Dr. Harold Schoenhaus, Dr. Michael Troiano and Dr. Daniel Perez

PATIENT NAME \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Telephone #(\_\_\_\_) \_\_\_\_\_ Cell #(\_\_\_\_) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Tel#(\_\_\_\_) \_\_\_\_\_ Work #(\_\_\_\_) \_\_\_\_\_

Employer Information \_\_\_\_\_

Address \_\_\_\_\_ Tel # \_\_\_\_\_

**Dr. Harold D. Schoenhaus**

*Podiatric Director - Penn Wound Care Center*

*Diplomate - American Board of*

*Foot & Ankle Surgery*

*Fellow - American College of*

*Foot & Ankle Surgery*

*Email: POD211@aol.com*

**Dr. Michael A. Troiano**

*Attending - Penn Wound Care Center*

*Diplomate - American Board of*

*Foot & Ankle Surgery*

*Fellow - American College of*

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*Email: michaeltroiano@msn.com*

**Dr. Daniel A. Perez**

*Associate - American Board of*  
*Foot & Ankle Surgery*

*Email: dperez8@gmail.com*

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 \_\_\_\_\_

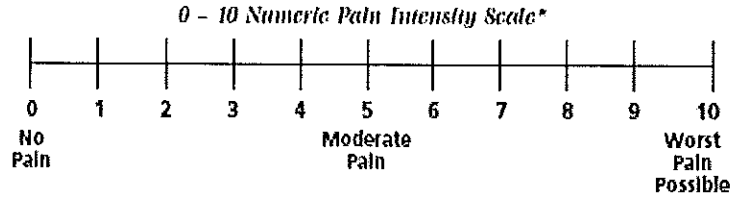
Telephone #(\_\_\_\_) \_\_\_\_\_

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

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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 \_\_\_ / \_\_\_ / \_\_\_

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 \_\_\_ / \_\_\_ / \_\_\_