SCHWEIN
Foot & Ankle Clinic

Dr. Jeffrey Schwein • Dr. Michael Swiatek

377 Marion Avenue • Mansfield, Ohio 44903 • Phone: 419-524-6772 • Fax: 419-524-3134

Office Hours:
Monday through Thursday: 8:00am-5:00pm
Friday: 8:00am-12:00pm
Closed daily for lunch: 12:00pm-1:15pm

Welcome

Dear Patient,

Welcome to Schwein Foot & Ankle Clinic. We are honored that you have chosen us to participate in your health care needs. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. Please take a moment to read over and complete the attached paperwork and return them to our office at your upcoming appointment.

Providing the highest quality of professional care to our patients is very important. Therefore, the following guidelines have been established:

- If a patient "No Shows" their first appointment, the patient will not be able to reschedule the appointment with our office.
- It is our policy that after two (2) "No Show" appointments.
- A pattern of rescheduling appointments could be grounds for dismissal.
- Prescription refill requests made outside of any appointment may take up to 48-hours for us to respond. Multiple requests will slow down the process.
- It may take up to two (2) weeks to receive lab or imaging results. However, abnormal results will be called to the patient within 24 business hours.
- Please bring your insurance card to every appointment.
- It is the patients' responsibility to know what services their insurance covers.
  -Including: lab work, imaging studies, and consultation services.

Thank you for choosing Schwein Foot & Ankle Clinic.

Sincerely,

The Physicians and Staff of Schwein Foot & Ankle Clinic

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PATIENT DEMOGRAPHICS: Please complete form in its entirety.

Last Name:_____ First Name:_____ MI:___

Maiden Name:_____ Nickname:_____

Check √ all that apply to the patient:

□ homeless □ does not have address □ does not have phone □ lives in nursing facility

Address:_____

City:_____ State:_____ Zip code:_____ County:_____

Email:_____

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

Preferred method of contact: □Home □Cell □Work May we leave a message? □YES □NO

Social Security Number:_____ Date of Birth:_____

Language:_____ Marital Status:_____ Gender: □MALE □FEMALE

Religious Affiliation:_____ Race:_____ Ethnicity: □Hispanic □Not Hispanic

EMERGENCY CONTACT INFORMATION:

Last Name:_____ First Name:_____ MI:_____

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

Phone Number: ( ) - _____ Relationship to Patient:_____

EMPLOYMENT:

Employer Name & Address:_____

Employer Phone Number: (____)_____

□Full-Time □Part-Time □Retired Retired date if applicable:_____

PATIENT MEDICAL INFORMATION:

Primary Care Provider Name (Family Physician):_____ □None

What is the primary reason for the patient's visit to our office?_____

_____

Name of Physician that referred you to our office?_____ □None

ADVANCED DIRECTIVES:

Check (√) any that apply. Please bring a copy of any advanced directive forms with you to your appointment.

□None □DNR (Do Not Resuscitate) □Living Will □Healthcare Proxy
□Durable POA (Power of Attorney)

GUARDIAN OR RESPONSIBLE PERSON (OF A MINOR OR OTHER PERSON):

Relationship to Patient:

□Mother □Father □Step-Mother □Step-Father □Foster Parent □Grandparent □Other:_____

Last Name:_____ First Name:_____ MI:_____

Employer Name/Address:_____

Gender: □Male □Female Social Security Number:___-___-___ Date of Birth:___/___/___

Address:_____

City:_____ State:_____ Zip code:_____ County:_____

Preferred Phone Number: (___)_____ Alternate Phone Number(___)_____

PATIENT MEDICATIONS:

Medication Name (brand or generic names)	**Medication Strength/Dosage** (example: 40mg or 5 oz.)	**Prescribed Medication Directions** (example: one pill daily by mouth at bedtime)

***If more space is needed for Medications, please attach a list to this form.*

PATIENT ALLERGIES:

Specific Allergy Name or Type (medications and environments)	**Bodily Reactions to the Allergy** (itching, breathing, stomach issues, etc.)	**Allergy Severity** (mild, moderate, severe)	**Onset Date**

***If more space is needed for Allergies, please attach a list to this form.*

PATIENT PAST MEDICAL AND SURGICAL HISTORY:

Have you ever had any problems or surgery in any of the body areas listed below? Check (√) Yes or No. If you answer YES to any of the areas, please list the specific disease or problem and other required information related to the disease.

Eyes: □ Yes □ No Ears: □ Yes □ No Nose/Throat: □ Yes □ No Lungs: □ Yes □ No

Bowel/Bladder: □ Yes □ No Liver: □ Yes □ No Kidney: □ Yes □ No Skin: □ Yes □ No

Muscle/Bone: □ Yes □ No Neurological: □ Yes □ No Endocrine: □ Yes □ No Stomach: □ Yes □ No

Heart: □ Yes □ No Bleeding/Clotting: □ Yes □ No Other/Not Listed: □ Yes □ No

□ Check (√) this box if the patient has no relevant past medical and surgical history.

Disease or Problem	**Date Diagnosed**	**Procedures, Surgeries, Tests, or Management of the Disease (include outcome & dates)**	**Additional Comments**

***If additional space is needed for Past Medical History, please attach a list to this form.*

PATIENT FAMILY MEDICAL HISTORY:

Have any of your family members (father, mother, sibling, children, or grandparents) ever had any problems or surgery in any of the body areas listed below? If you answer YES to any of the areas, please list the specific disease or problem and other required information related to the disease.

Eyes: □ Yes □ No Ears: □ Yes □ No Nose/Throat: □ Yes □ No Lungs: □ Yes □ No

Bowel/Bladder: □ Yes □ No Liver: □ Yes □ No Kidney: □ Yes □ No Skin: □ Yes □ No

Muscle/Bone: □ Yes □ No Neurological: □ Yes □ No Endocrine: □ Yes □ No Stomach: □ Yes □ No

Heart: □ Yes □ No Bleeding/Clotting: □ Yes □ No Other/Not Listed: □ Yes □ No

□ Check (√) this box if the patient has no relevant family medical history.

Diagnosis or Problem	Family Member Relation	Age of Onset	Age of Death (if applicable)	Additional Comments

***If additional space is needed for Family History, please attach a list to this form.*

Tobacco, Alcohol, and Caffeine Use:

Tobacco Use (check (√) one): □Current □Former □Never □Unknown

Type of Tobacco use:_____ Units/Packs per day:_____ Years used:_____

Do you consume Alcohol? (check (√) one): □Yes □No

Type of Alcohol:_____ Frequency/Amount:_____

Do you consume caffeine? (check (√) one): □Yes □No

Caffeine Type(s): □Coffee □Chocolate □Energy Drink □Tea □Other

Amount consumed per day:_____

INSURANCE INFORMATION:

Primary Ins. Co.:_____ Insured's Name:_____

Insured's Social Security#:_____ Date of Birth:_____

Employer:_____ Employer phone#:_____ Co pay:$_____

Secondary Ins. Co.:_____ Insured's Name:_____

Insured's Social Security#:_____ Date of Birth:_____

Employer:_____ Employer phone#:_____ Co pay:$_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I was 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 understand the Notice:

Patient Signature:_____ Date:_____
Parent or Authorized Representative:_____
Please print PATIENT NAME:_____

AUTHORIZATION TO RELEASE INFORMATION:

*** I hereby authorize the SCHWEIN FOOT AND ANKLE CLINIC and/or their staff to disclose my individually identifiable health information necessary to determine liability for payment and to obtain reimbursement on any claim, Medicare or private health insurance.
*** I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, and private health insurance companies to SCHWEIN FOOT AND ANKLE CLINIC.
*** I understand that I am financially responsible for all charges whether or not paid by said Medicare, Insurance or Private Pay.

I AGREE TO THE ASSIGNMENT AND FINANCIAL RESPONSIBILITIES AS STATED ABOVE:

Signature:_____ **Date:**_____

NO SHOW POLICY:

- A $25.00 fee will be charged for appointments not cancelled within TWENTY-FOUR (24) hours of the scheduled appointment time.
- A $25.00 fee will be charged if you do not come in for your appointment (NO SHOW).
- A $25.00 fee will be charged if you are LATE for your appointment and you may be asked to reschedule.
- You may be asked to pay your fee before scheduling your next appointment.
- Dr. Schwein and Dr. Swiatek may release you from the practice if you have Two (2) or more NO SHOWS.

Signature:_____ Date:_____

Many of our patients allow family members or caretakers such as spouse, parents, or others to call and request medical and/or billing information. Under the requirements of HIPAA we are NOT ALLOWED to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to family members or caretakers, you must sign this form. Signing this form will give us permission to speak with ONLY the persons you indicated below.

I AUTHORIZE SCHWEIN FOOT AND ANKLE CLINIC TO RELEASE MY MEDICAL AND/OR BILLING INFORMATION TO THE FOLLOWING INDIVIDUAL(S):

1._____ Relationship to patient:_____

2._____ Relationship to patient:_____

3._____ Relationship to patient:_____

I understand I have the right to revoke this authorization at any time in writing.

I understand that information disclosed to any above individual(s) is no longer protected by Federal or State Law and may be subject to re-disclosure by above individual(s).

Patient Signature:_____ Date:_____

Parent or Authorized Representative:_____

Please print PATIENT NAME:_____