Amy B. Schunemeyer, DPM

Patient Information: (Please complete all information by printing)

Today's date: _____

Last Name: _____ **First Name**: _____ **Middle Initial:** _____

Sex: Male/Female Patient's Social Security # _____ Marital Status: Single/Married/Other

Patient's Date of Birth: _____**Race**: White/Black/Am Indian or Alaska Native/Asian/Native Hawaiian

Ethnicity:Hispanic or Latino/Not Hispanic or Latino **Primary Language**:_____

Address: _____ **City/State**: _____**Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address:_____**Student:** F/T or P/T

Place of Employment: _____ **Occupation:** _____

Were you referred here? _____

If so, Referring Physician:_____ **Reason for referral:** _____

Primary Care Physician: _____ Phone: _____

Primary pharmacy used? _____ Phone:_____

Please list the Guarantor: (the person that is responsible for the patient's portion of the bill):

Name::_____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please list two emergency contacts: (one that does not live with you)

Name and address:_____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name and address:_____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance Information: (please complete all information by printing)

Insurance: _____ ID#: _____ Group#: _____

Effective date of coverage: _____ Benefit Phone Number: _____

Insured Name: _____ Relationship to Patient: _____

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

Insured: Place of Employment: _____ Employer Phone #: _____

Employer Address: _____

Secondary Insurance Information: (please complete all information by printing)

Insurance: _____ ID#: _____ Group#: _____

Effective date of coverage: _____ Benefit Phone Number: _____

Insured Name: _____ Relationship to Patient: _____

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

Insured: Place of Employment: _____ Employer Phone #: _____

Employer Address: _____

It is also required for identity purposes that we see a picture ID and your insurance card on every visit, this law was established to help protect your identity from theft.

Our office strives on providing you with quality healthcare in a timely fashion. Unfortunately there are times where your waiting period is longer than you would expect to wait due to unforeseen patient circumstances. We ask that you please be patient and understanding as if there was a complication with your care you would expect the same quality of care. If the wait time is longer than you are able to wait please notify the office manager and she will schedule you at a time that is convenient for you with less of a waiting period.

We ask as a courtesy to other patient and yourself that you give us a 24 hour advanced notice for appointment cancelations or re-schedules. A $25.00 charge will be applied for all missed appointments that have not been cancelled or re-schedule within 24 hours of your scheduled appointment time.

My signature below also acknowledges that I have received a copy of Dr. Schunemeyer's HIPPA compliance form.

Patient Signature: _____ Date:_____

We now offer Patient Portal, where we can now exchange secure medical information via the web through the email address you have provided us. If you would like to have your account set up for this feature please circle the correct response, provide us with the email address you would like us to use and sign acknowledging that you are approving the use of this feature and that you have received a copy of the Terms and Use agreement.

Yes/No Email Address: _____

Patient Signature: _____ Date:_____