

**NEIL S. SNYDER, DPM  
MEREDITH B. STUART, DPM  
PODIATRY  
FOOT SURGERY**

NORTH COUNTY  
12410 LUSHER ROAD  
ST. LOUIS, MO 63138  
(314) 355-2230  
FAX (314) 355-2233  
[www.feetonline.net](http://www.feetonline.net)

WEST COUNTY  
16087 MANCHESTER ROAD  
ELLISVILLE, MO 63011  
(636) 230-3883  
FAX (636) 230-3884

---

DISEASES OF THE FOOT AND ANKLE.  
DIPLOMATE, AMERICAN COUNCIL OF CERTIFIED PODIATRIC PHYSICIANS AND SURGEONS

---

**REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

**Name of Patient:** \_\_\_\_\_  
(Please print)

**Date of Birth:** \_\_\_\_\_

I request that all communications to me (by telephone, mail, email or otherwise) by **Neil S. Snyder, DPM or Meredith B. Stuart, DPM** and/or its staff be handled in the following manner:

- For written communications: Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Email: \_\_\_\_\_
  
- For oral communications: \_\_\_\_\_  
(Telephone number)  
  
May we leave a message?  
 Yes       No

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

For Practice Use Only

Practice:      Accepts       Denies

Privacy Officer Signature: \_\_\_\_\_

**PATIENT INFORMATION** Please fill out this form completely and bring it with you to your appointment.

Date: \_\_\_ / \_\_\_ / 20\_\_\_ Soc. Sec. #: \_\_\_ - \_\_\_ - \_\_\_ Birth date: \_\_\_ / \_\_\_ / \_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_ - \_\_\_ - \_\_\_

Sex: M F (circle one)

Minor  Single  Married  Long-Term Partner  Divorced  Widowed  Separated  (check one)

Employer: \_\_\_\_\_ Bus. Phone: \_\_\_ - \_\_\_ - \_\_\_

Bus. Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Who should we thank for referring you? \_\_\_\_\_

In case of emergency, who should we contact? \_\_\_\_\_ Phone: \_\_\_ - \_\_\_ - \_\_\_

**PRIMARY INSURANCE**

Person Responsible for Account:

Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Birth date: \_\_\_ / \_\_\_ / \_\_\_ Soc. Sec. #: \_\_\_ - \_\_\_ - \_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_ - \_\_\_ - \_\_\_

Responsible Party Employed By: \_\_\_\_\_

Bus. phone: \_\_\_ - \_\_\_ - \_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**ADDITIONAL INSURANCE (IF APPLICABLE)**

Insured Name:

Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Birth date: \_\_\_ / \_\_\_ / \_\_\_ Soc. Sec. #: \_\_\_ - \_\_\_ - \_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_ - \_\_\_ - \_\_\_

Insured Employed By: \_\_\_\_\_ Bus. Phone: \_\_\_ - \_\_\_ - \_\_\_

Business Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I hereby authorize payment directly to Dr. Neil Snyder / Dr. Meredith Stuart for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

**REASON FOR VISIT**

Please list your present health concerns, problems, or symptoms: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

When was your last physical exam? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1. Are you currently under medical treatment? ..... Yes  No

Please describe: \_\_\_\_\_

2. Have you ever had any serious illnesses or operations? ..... Yes  No

Please describe: \_\_\_\_\_

3. Are you currently taking any medication? ..... Yes  No

Please describe: \_\_\_\_\_

4. Do you smoke? ..... Yes  No

Please describe: \_\_\_\_\_

5. Do you use alcohol? ..... Yes  No

Please describe: \_\_\_\_\_

6. Do you use cocaine or other drugs? ..... Yes  No

Please describe: \_\_\_\_\_

7. Have you had any allergic reactions to the following?

- |                                 |  |                       |  |           |  |
|---------------------------------|--|-----------------------|--|-----------|--|
| Local Anesthetics               | Yes <input type="checkbox"/> No <input type="checkbox"/> | Adhesive/Tape         | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sedatives | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Penicillin or other Antibiotics | Yes <input type="checkbox"/> No <input type="checkbox"/> | Anticoagulant Therapy | Yes <input type="checkbox"/> No <input type="checkbox"/> | Iodine    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Sulfa Drugs                     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Codeine               | Yes <input type="checkbox"/> No <input type="checkbox"/> | Aspirin   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Barbiturates (sleeping pills)   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Demerol               | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Novocain                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Seafood               | Yes <input type="checkbox"/> No <input type="checkbox"/> |           |  |

Please describe: \_\_\_\_\_

8. Women only: Are you taking birth control pills? ..... Yes  No

**MEDICATIONS**

Include prescriptions, over-the-counter medications and vitamins: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name(s) and Phone Number(s): \_\_\_\_\_

\_\_\_\_\_

Place a mark on “Yes” or “No” to indicate if you have ever had any of the following.

Anemia (low blood count)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gout	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pneumonia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Angina	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Polio	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anorexia (no appetite)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Prostate Problem	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Valves or Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis-Type ____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hernia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemical Dependency	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Latex Sensitivity	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chicken Pox	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Fatigue	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Circulatory Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Measles	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Lesions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Migraine Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cough (persistent or bloody)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mumps	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any Other Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Multiple Sclerosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Describe: _____	
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	
Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	
Foot or Leg Cramps	Yes <input type="checkbox"/> No <input type="checkbox"/>	Phlebitis	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Surgeries you have had: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospitalization other than for the surgeries listed: \_\_\_\_\_

\_\_\_\_\_

Family physician: \_\_\_\_\_ Last visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you now, or have you been, under any other doctor’s care for any reason over the past two years? Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**CONSENT**

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_