

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

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DISEASES OF THE FOOT AND ANKLE.

DIPLOMATE, AMERICAN COUNCIL OF CERTIFIED PODIATRIC PHYSICIANS AND SURGEONS

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**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: \_\_\_ - \_\_\_ - \_\_\_

Email address: \_\_\_\_\_ May we contact you by email? Yes or No 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  No   
Penicillin or other Antibiotics Yes  No   
Sulfa Drugs Yes  No   
Barbiturates (sleeping pills) Yes  No   
Novocain Yes  No

Adhesive/Tape Yes  No   
Anticoagulant Therapy Yes  No   
Codeine Yes  No   
Demerol Yes  No   
Seafood Yes  No

Sedatives Yes  No   
Iodine Yes  No   
Aspirin Yes  No   
Other Yes  No

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: \_\_\_\_/\_\_\_\_/\_\_\_\_