WELCOME

PATIENT INFORMATION

Date _____

SS# _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

INSURANCE

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to FOOT AND ANKLE CENTER OF OCALA, P.A. for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

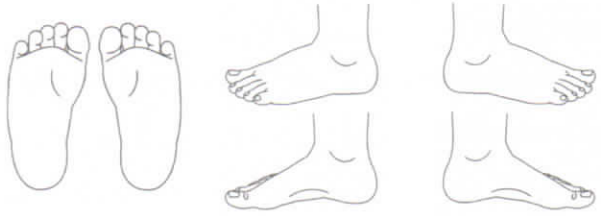
_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

CHIEF COMPLAINT:

Please indicate the source of the pain on the diagrams below:



Please indicate which foot problems you now have:

Ankle Pain	☐ Yes	☐ No
Athlete's Foot	☐ Yes	☐ No
Bunions	☐ Yes	☐ No
Corns and Calluses	☐ Yes	☐ No
Cramps or numbness in Feet or Legs	☐ Yes	☐ No
Flat Feet	☐ Yes	☐ No
Foot or Leg Cramps	☐ Yes	☐ No
Heel Pain	☐ Yes	☐ No
Ingrown Toenails	☐ Yes	☐ No
Plantar Warts	☐ Yes	☐ No
Swelling in Ankles or Feet	☐ Yes	☐ No
Tired Feet	☐ Yes	☐ No

HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh and hip complaints.)

_____

_____

_____

Have you ever been to a Podiatrist before?

☐ Yes ☐ No

If yes, please list.

Name _____

Last visit _____

Is there any personal or family history of diabetes?

☐ Yes ☐ No

Your occupation _____

Cigarette/Tobacco use _____

Years smoked _____

Alcohol use:

☐ Occassional ☐ Heavy ☐ Social

Height: _____

Weight: _____

Please fill out the following:

Mother ☐ Deceased ☐ Alive

Father ☐ Deceased ☐ Alive

Medical History:

Mother: _____

_____

_____

Father: _____

_____

_____

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Allergies to Medicine or Drugs	☐ Yes ☐ No	Eye Problems	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Artificial Heart Valves or Joints	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis or Jaundice	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Varicose Veins	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Chronic Diarrhea	☐ Yes ☐ No	Phlebitis	☐ Yes ☐ No	Immunosuppresant	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Therapies	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Hypothyroidism	☐ Yes ☐ No
Ear Problems	☐ Yes ☐ No	Acid Reflux	☐ Yes ☐ No		

Surgeries you have had _____

_____

_____

Family Physician _____

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 _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Anticoagulant Therapy	☐ Local Anesthetics
☐ Aspirin	☐ Novocaine
☐ Codeine	☐ Penicillin
☐ Demerol	☐ Seafoods
☐ Iodine	☐ Sulfa
☐ Medication Allergies	☐ Other_____
☐ No Known Allergies	_____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient