Thomas R. Fann, DPM
Florida Foot & Ankle Group, P.A.
Patient Information Sheet

PLEASE PRINT LEGIBLY WITH BLACK INK Today's Date: _____

Name: _____ Social Security #: _____ - _____ - _____

Date of Birth: _____/ _____/ _____ Age: _____ Sex: □ Male □ Female

Address: _____
Street City State Zip

Home Phone: (_____) _____ Cell Phone: (____) _____

Work Phone: (_____) _____Ext/ Dept: ____ Employer: _____

Marital Status: □ Single □ Married □ Widow(er)

How were you referred to us? □ Friend/ Family (Name): _____
□ Location □ Yellow Pages □ Physician (Name): _____
□ Internet □ I am a Former Patient □ Insurance Company

Emergency Contact: _____ Phone: (____) _____
Name/ Relationship

Primary Care Physician: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

INSURANCE INFORMATION

Insurance Plan: _____ Primary Insured: _____

Insured's Date of Birth: _____/ _____/ _____ Relation to Patient: _____

Insured's Employer: _____

PLEASE READ AND SIGN

It is the patient's responsibility to keep us informed of your current and correct insurance information. Please make sure you are acquainted with the correct participating physicians, facilities, and labs covered by your individual insurance company.

If injured at work, you must notify us prior to being seen so that we may verify your coverage. If you fail to do so, or your claim is denied, you will be responsible for all fees. If you are involved in litigating a claim for medical treatment, you will remain responsible for all fees, unless prior arrangements have been made.

_____ _____
Signature of Patient or Responsible Party Date

Florida Foot & Ankle Group, P.A.
Patient Health History

Name: _____ Age: ____ Sex: M/ F Race: _____

Reason for today's visit: _____

Is this a result of an injury? If so, explain: _____

Where & when did this occur? _____

Height: _____ Weight: _____ Shoe Size: _____

Current Medical Conditions/ Illnesses: _____

_____

Current Medications and what they are taken for: _____
(Attach list if more than 3)

_____

Allergies (drugs, tapes, iodine, foods): _____

List any hospitalizations/ surgeries you have had in the past 5 years: _____

_____

List any foot surgeries ever: _____

Do any family members have: □ Arthritis □ High Blood Pressure □ Diabetes □ Cancer □ Gout
□ Blood/ Bleeding Problems □ Heart Problems □ Foot Problems

Do you smoke cigarettes? □ Yes □ No Have you ever? □ Yes □ No
Do you drink alcohol? □ Yes □ No If yes, frequency: _____
Do you exercise? □ Yes □ No Explain: _____
Do you spend time on your feet at work? □ Yes □ No Occupation: _____

Family Doctor/ Internist: _____ Date Last Seen: _____
Other Dr's you see: _____ Date Last Seen: _____
_____ _____

Do you/ have you had any of the following conditions or illnesses:

□ Yes	□ No	Arthritis	□ Yes	□ No	Poor circulation	□ Yes	□ No	Lung/ breathing problems
□ Yes	□ No	Cancer	□ Yes	□ No	Bleeding Problems	□ Yes	□ No	Trauma to feet/ legs
□ Yes	□ No	Gout	□ Yes	□ No	Poor healing	□ Yes	□ No	Cramping of feet/ legs
□ Yes	□ No	Tuberculosis	□ Yes	□ No	Nerve problems	□ Yes	□ No	Swelling of feet/ legs
□ Yes	□ No	Diabetes Mellitus	□ Yes	□ No	Numbness in feet	□ Yes	□ No	Ear/eye/nose/throat problems
□ Yes	□ No	Rheumatic Fever	□ Yes	□ No	Low back pain	□ Yes	□ No	Infections/ contagious disease
□ Yes	□ No	Heart Problems	□ Yes	□ No	Weight loss/ gain	□ Yes	□ No	Hepatitis, AIDS, VD
□ Yes	□ No	Stomach Ulcers	□ Yes	□ No	High blood pressure	□ Yes	□ No	Blood transfusion
□ Yes	□ No	Phlebitis	□ Yes	□ No	Liver Problems	□ Yes	□ No	Stroke
□ Yes	□ No	Anemia	□ Yes	□ No	Kidney Problems	□ Yes	□ No	Other _____

Explain Yes Responses: _____

The above information is complete and accurate to the best of my knowledge. I hereby give permission to Florida Foot & Ankle Group, P.A. to examine, perform necessary diagnostic testing, and treat my foot or ankle condition. I authorize photographing my feet.

Patient/ Parent/ Guardian Signature: _____ Date: _____