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Tampa, Florida 33615
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Patient Information

for office use only

THIS FORM MUST BE COMPLETED IN FULL

Patient # _____

Patient Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Sex: M F Marital Status: S M D Sep W

Patient Employed By: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Spouse's Name: _____

Spouse Employed By: _____ Business Phone: _____

Business Address: _____

Referral: Who referred you to this office? Name: _____

Address: _____

Telephone: _____

Pharmacy: What pharmacy do you use? _____ Phone: _____

What is your primary foot problem? _____

Former foot doctor: _____ Last Visit: _____

Family Physician: _____ Phone: _____

Are you now or have you been under a physician's care during the past 2 years? Yes No

Are you taking blood thinners? (Coumadin, Aspirin) Yes No

Are you diabetic? Yes No Is there a family history of diabetes? Yes No

Have you ever experienced an allergic reaction to: **(Check all that apply)**

Novocain Adhesive Tape Latex Penicillin Sulfa

Any other allergies? _____

Have you ever been treated for: **(Check all that apply)**

Heart Trouble Asthma Epilepsy Rheumatic Fever Kidney Problems
 Nervous Disorder Hepatitis Other: _____

Do you require any specific medications prior to any surgery or dental work? Yes No

Have you ever had any problems with excessive bleeding? Yes No

Do you smoke? Yes No # of packs per day: _____

Previously smoked? Yes No # of years: _____

Do you drink? Yes No If yes, how often? 1-2 per week 1-2 per day more

RESPONSIBLE PARTY (if other than patient)

Name: _____

Social Security #: _____ Relation to patient: _____

Billing Address: _____

City, State, Zip: _____

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

E-Mail Address: _____

Employer's Name: _____

Address: _____

Phone: _____ Marital Status: S M W D

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

Name: _____

Address: _____

Policy Holder's Name: _____ Relation to patient: _____

Policy #: _____ Group #: _____

Policy holder sex: M F Birth Date: _____

SECONDARY INSURANCE COMPANY

Name: _____

Address: _____

Policy Holder's Name: _____ Relation to patient: _____

Policy #: _____ Group #: _____