

SHEEHY PODIATRIC MEDICAL CENTER

2009 PATIENT INFORMATION FORM

PATIENT LAST NAME: _____ FIRST: _____ INITIAL: _____
DATE OF BIRTH month: _____ date: _____ year: _____ sex: (F) ____ (M) ____
SOCIAL SECURITY NUMBER: _____
ADDRESS: _____
CITY, STATE _____ ZIP CODE _____
HOME TELEPHONE: () _____ WORK TELEPHONE: () _____
EMPLOYER: _____ RETIRED: _____ DISABLED: _____
DRIVER'S LICENSE NUMBER: _____
CONTACT PERSON IN CASE OF EMERGENCY: _____
TELEPHONE: () _____ RELATIONSHIP: _____

What is the chief complaint for which you came to be treated? _____

Have you been to a Podiatrist before YES _____ NO _____

If yes name: _____ When _____

INSURANCE INFORMATION

Primary Health Insurance _____
Policy Number _____
Group Number _____
Telephone Number on the Back of Card _____
Type of Coverage: Family _____ Individual _____
Amount of the Co-Pay \$ _____

Secondary Health Insurance _____
Policy Number _____
Group Number _____
Telephone on the Back of Card _____
Type of Coverage: Family _____ Individual _____

I authorize Dr. Sheehy to diagnose, treat and evaluate my medical condition, and I am responsible for all charges which are not covered by my Insurance Company.

PATIENT SIGNATURE: _____ DATE: _____
Primary Care Physician: _____ Telephone Number: () _____

14. _____

13. _____

12. _____

11. _____

10. _____

9. _____

8. _____

7. _____

6. _____

5. _____

4. _____

3. _____

2. _____

1. _____

HOW OFTEN

MEDICATION

PATIENT MEDICATIONS

SHEEHY PODIATRIC MEDICAL CENTER
 Paul L. Sheehy, Jr. D.P.M.
 812 W. Martin Luther King Jr. Blvd, Suite 101, Tampa Fl. 33603
 OFFICE: (813) 872-8939 FAX: (813) 8728649

SHEEHY PODIATRIC MEDICAL CENTER

Paul L. Sheehy, Jr. D.P.M.

MEDICAL HISTORY

PATIENT'S NAME: _____ DATE: _____

LAST PHYSICAL EXAM: _____

PRIMARY PHYSICIAN: _____

Please Mark (X) if you have any of the following :

- AID/HIV ()
- Allergies to Anesthetics ()
- Allergies to Medicine
- or Drugs()
- Anemia()
- Angina()
- Arthritis()
- Artificial Heart Valves
- or Joints()
- Asthma()
- Back Problems()
- Bleeding Disorders()
- Cancer ()
- Chemical Dependency()
- Chest Pain()
- Chronic Diarrhea()
- Circulatory Problems()
- Diabetes()
- Ear Problems ()
- Epilepsy()
- Eye Problems()
- Fainting()
- Foot or Leg Cramps()
- Gout()
- Headaches()
- Heart Disease()
- Homophilia()
- Hepatitis()
- High Blood Pressure()
- Kidney Problems()
- Liver Disease()
- Low Blood Pressure()
- Nervous Problems ()
- Phlebitis()
- Pneumonia()
- Psychiatric Care()
- Radiation Treatment()
- Rash()
- Respiratory Disease()
- Rheumatic Fever()
- Shortness of Breath()
- Sinus Problems()
- Special Diet()
- Stroke()
- Swelling in Ankles, Feet()
- Swollen Neck Glands()
- Tired Feet()
- Tuberculosis()
- Ulcers()
- Varicose Veins()
- Veneral Disease()
- Weight Loss, unexplained()
- OTHER()

MEDICAL HISTORY

SURGERIES YOU HAVE HAD

HOSPITALIZATION OTHER THAN
FOR THE SURGERIES LISTED

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) :

ALLERGIES :

- ADHESIVE /TAPE ()
- ANTICOAGULANT THERAPY ()
- ASPIRIN ()
- CODEINE ()
- DEMEROL ()
- IODINE ()
- LOCAL ANESTHETICS ()
- NOVACAIN ()
- PENICILLIN ()
- SEA FOODS ()
- SULFA ()

I CERTIFY THAT THE ABOVE INFORMATION IS THE TRUE AND CORRECT TO THE BEST OF
MY KNOWLEDGE. I GIVE MY PERMISSION TO THE DOCTOR TO ADMINISTER AND
PERFORM SUCH PROCEDURE AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR
TREATMENT OF MY FEET, ANKLE, AND/OR LEG.

PATIENT'S SIGNATURE

DATE

Notice of Privacy Practice Patient Acknowledgment

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practice written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect. Types of uses and disclosures that this practice is permitted to make for each of the following purpose: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protect health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will only be made in written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and brief description of how I may exercise these rights in relation to:

- The right to complain to this practice and the secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complain.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to receive confidential communications of protected health information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy from this practice upon request.

The practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy an request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient): _____