SHEEHY ANKLE FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director

COVID-19 SCREENING

Patient Name: _____

Date: _____

Please let us know if you have had any of the following:

	YES	NO
Fever greater than 100F	☐	☐
Cough/Shortness of Breath	☐	☐
Pneumonia/flu – recent	☐	☐
Have you traveled out of the country in the last 14 days to China, Japan, Italy, Iran, or S. Korea	☐	☐
Have you had contact with anyone who has lab confirmed Coronavirus within 14 days of symptom onset?	☐	☐
Have you been on a cruise in the last 14 days?	☐	☐
Have you been vaccinated?	☐	☐

1st dose: _____
2nd dose: _____
Booster: _____

Patient Signature: _____

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Welcome to SHEEHY ANKLE & FOOT CENTER OF TAMPA BAY

PATIENT INFORMATION

We are pleased to Welcome you to our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions, we'll be glad to help you.

Last Name: _____ First Name: _____ Middle Initial _____ Date: _____
Soc. Sec. #: _____ Driver's License #: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Mailing Address (if different): _____
Sex: ☐M ☐F Age: ____ DOB:___/___/___ Marital Status: Single / Married / Divorced / Widowed / Other
Patient employed by: _____ Occupation: _____
May we call you at work? Yes / No Work Hours: _____ Work Phone: _____
Business Address: _____
Emergency Contact: _____ Relationship to patient: _____
Home Phone: _____ Cell Phone: _____ Business Phone: _____
How did you hear about us? _____

HEALTH INSURANCE INFORMATION (Copy of card is required; verification for each visit.)

Primary Insurance Coverage

Insurance Company _____ Phone # _____
Contract # _____ Group # _____ Subscriber # _____
Annual Deductible _____ Specialist Deductible _____ Is Deductible Met? ☐ Yes ☐ No
Co-Pay for Specialist _____ (Payment is required prior to service)
Person responsible for account _____ DOB ___/____/_____
Relation to patient _____ Soc. Sec. # _____ Home phone_____
Address (if different from patient) _____
Person responsible employed by _____ Occupation _____
Business Address _____ Business Phone _____

Secondary Health Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No Annual Deductible Met? ☐ Yes ☐ No
Secondary Insurance Company _____ Phone # _____
Contract # _____ Group # _____ Co-Pay Amount _____
Person responsible for account _____ Relation to Patient _____

SHEEHY ANKLE FOOT CENTER
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Primary Care Physician Name _____ Last Visit_____

Address _____ Phone # _____

What is the nature of your foot problem? _____

_____

Is your foot problem related to: Auto Accident _____ Employment _____ Other _____

Height _____ Weight _____ Shoe Size _____ Last blood pressure count _____

Are you in good general health? ☐ Yes ☐ No If no, explain _____

_____

Are your feet tired at the end of the day? ☐ Y ☐ N Do you have lower back pain? ☐ Y ☐ N

Have you ever broken a bone in your foot or ankle? ☐ Y ☐ N

Have you had any previous foot/ankle surgery? ☐ Y ☐ N

Do you use tobacco products? ☐ Y ☐ N If yes, what amount daily? _____

MEDICAL HISTORY

Check if you have had any of the following:

☐ Arthritis, Rheumatism	☐ Cramps/Numbness in feet or legs	☐ Kidney trouble
☐ Asthma	☐ Swelling of feet or ankles	☐ Liver trouble
☐ Bleeding disorder	☐ Diabetes	☐ Varicose veins
☐ Eye Trouble	☐ Heart trouble	☐ High blood pressure

List any other medical problems: _____

Are you allergic/sensitive to:

☐ Anesthetics	☐ Novocain	☐ Sulfa Drugs
☐ Drugs	☐ Penicillin	☐ Latex
☐ Foods	☐ Tape	
☐ Materials	☐ Other: _____	

List of surgeries: _____

List of medications you are currently taking, if any:

_____ _____ _____

_____ _____ _____

NAME: _____ DOB: _____

REVIEW OF SYSTEMS

NOTES

GENERAL CONSTITUTIONAL		
Recent weight loss	No	Yes
Fever	No	Yes
Chills	No	Yes

EYES/VISION		
Vision changes	No	Yes

EARS, NOSE, & THROAT		
Hearing loss	No	Yes

HEART/CARDIOVASCULAR		
Chest pain or pressure	No	Yes
Arrythmia or palpitations	No	Yes
Shortness of breath	No	Yes
Peripheral edema	No	Yes
Blood clots	No	Yes
Varicose veins	No	Yes
Cramping in thighs	No	Yes

RESPIRATORY		
Cough	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

GASTROINTESTINAL		
Abdominal pain	No	Yes
Heartburn	No	Yes
Bloody stool	No	Yes

GENITOURINARY		
Frequent urination	No	Yes

NAME: _____ DOB: _____

Urgency	No	Yes

MUSCULOSKELETAL		
Joint pain or swelling	No	Yes
Restricted motion	No	Yes
Musculoskeletal pain	No	Yes

SKIN & INTEGUMENTARY		
Rashes	No	Yes
Sores	No	Yes
Blisters	No	Yes
Growths	No	Yes

NEUROLOGICAL		
Numbness or tingling	No	Yes
Sensation loss	No	Yes
Burning	No	Yes

PSYCHIATRIC		
Nervousness, anxiety	No	Yes
Depression	No	Yes

ENDOCRINE		
Heat or cold intolerance	No	Yes
Excessive thirst	No	Yes

HEMATOLOGIC/LYMPHATIC		
Abnormal bleeding	No	Yes
Bleeding	No	Yes

ALL/IMMUNOLOGIC		
Allergic Reaction	No	Yes
Recurrent infections	No	Yes

SIGNATURE: _____ DATE: _____

SHEEHY ANKLE FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director

PATIENT: _____
DATE: _____
PREFERRED PHARMACY: _____

LIST OF MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

ALLERGIES

1. _____
2. _____
3. _____
4. _____
5. _____

SHEEHY ANKLE FOOT CENTER
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AUTHORIZATION FOR TREATMENT

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this information on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits.

I understand that if I am in default of payment, I will be responsible for any attorney or collection fees.

Signature: _____ **Date:** _____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the PAUL L. SHEEHY, JR., D.P.M., for any services furnished me by the physician. I authorize any holder of medical information about me to release PAUL L. SHEEHY, JR., D.P.M., and its agents any information needed to determine these benefits or benefits payable for related services.

Signature: _____ **Date:** _____

SECONDARY INSURANCE
I understand that my secondary claim is billed as courtesy only and will be submitted to the appropriate party ONE TIME. After that one-time submission if the insurance company does not pay within 60 days or denies the claim, I (the patient) will be financially responsible to pay.

Signature: _____ **Date:** _____

PATIENT AGREEMENT
I understand that payment is due at the time of service, including co pays and/or deductible. I certify that the information provided on this form is correct. I authorize the release of information including medical information to this organization and all insurance organizations involved with my claim. I understand that if I am in default of payment, I will be responsible for any attorney or collection fees. I authorize my physician to prescribe medication and to give me reasonable and proper medical care by today's standards.

Signature: _____ **Date:** _____

SHEEHY ANKLE FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director

ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the HIPAA Federal Privacy Guidelines and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

SHEEHY ANKLE & FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director
4144 N Armenia Ave., #230, Tampa, FL 33607
Office Ph#: (813) 872-8939 | Fax#: (813) 872-8649

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, D.O.B.: _____;

Hereby authorize _____ to release my medical records, including but not limited to, operative reports, radiology reports, film copies, pathology reports, slides, and discharge summaries to: PAUL L. SHEEHY, Jr., D.P.M.

_____ _____

Patient Signature Date

SHEEHY ANKLE FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ☐ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ☐ Obtain payments from third party payers.
- ☐ Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that your **Notice of Privacy Practices** contains a more complete description of the uses and disclosures of my health information and a copy is available to me upon my request. I understand that Dr. Paul L. Sheehy, Jr., DPM of Sheehy Ankle & Foot Center of Tampa Bay has the right to change its **Notice of Privacy Practices** from time to time and that I may contact Dr. Paul L. Sheehy, Jr., DPM of Sheehy Ankle & Foot Center of Tampa Bay to obtain a current copy of the **Notice of Privacy Practices** at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions.

The following is a listing of the person or persons (usually a spouse) whom I authorize to have access to my medical and billing records at this facility.

Name: _____

Relationship: _____

Signature: _____ **Date:** _____

NAME: _____ DATE: _____

Do I Need a Test for PAD?

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, and kidneys become narrow or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, blood pressure that is difficult to control, or symptoms of stroke. People with PAD are at a significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check All Applicable Boxes

1. Do you have foot, calf, buttock, hip, or thigh discomfort (aching, fatigue, tingling, cramping, or pain) when you walk which is relieved by rest? ☐
2. Do you have a history of cardiovascular disease or diabetes and experience any pain or swelling at rest in your lower legs or feet? ☐
3. Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that often disturbs your sleep? ☐
4. Do you have an ulcer on your thigh, calf, ankle, foot, or toe that is slow to heal? ☐
5. Do you have diabetes and unusual hair loss or skin discoloration in your legs? ☐
6. Do your fingers or toes feel numb or cold in response to temperature changes or stress? ☐
7. Have you suffered a severe injury to your leg(s) or feet? ☐
8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? ☐
9. Have you had blockages in your coronary or heart arteries? ☐

Other Comments or Notes: _____

_____

_____

Patient Signature: _____ Date: _____

Note: Providers are advised that insurance carriers have policies regarding when diagnostic services are considered medically necessary. These policies may vary between carriers and are subject to change at any time. Providers should check coverage requirements with specific insurance plans before testing.

Falls Efficacy Scale-International (English)

I would like to ask some questions about how concerned you are about the possibility of falling. For each of the following activities, please circle the option closest to your own to show how concerned you are that you might fall if you did this activity. Please reply thinking about how much you usually do the activity. If you currently don't do the activity (example: if someone does the shopping for you), please answer to show whether you think you would be concerned about falling IF you did the activity.

		Not at all concerned 1	Somewhat concerned 2	Fairly concerned 3	Very concerned 4
1	Cleaning the house (e.g. sweep, vacuum, dust)				
2	Getting dressed or undressed				
3	Preparing simple meals				
4	Taking a bath or shower				
5	Going to the shop				
6	Getting in or out of a chair				
7	Going up or down stairs				
8	Walking around in the neighborhood				
9	Reaching for something above your head or on the ground				
10	Going to answer the telephone before it stops ringing				
11	Walking on a slippery surface (e.g. wet or icy)				
12	Visiting a friend or relative				
13	Walking in a place with crowds				
14	Walking on an uneven surface (e.g. rocky ground, poorly maintained pavement)				
15	Walking up or down a slope				
16	Going out to a social event (e.g. religious service, family gathering, or club meeting)				
	Sub Total				
				TOTAL	/64

Reference: Yardley, L., Beyer, N., Hauer, K., Kempen, G., Piot-Ziegler, C., & Todd, C. (2005). Development and initial validation of the Falls Efficacy Scale-International (FES-I). *Age and Ageing*, 34(6), 614-619. Doi:10.1093/ageing/afi196.

Sherry Greenberg wishes to acknowledge that the development of this document was funded in part by a Ruth L. Kirschstein National Research Service Award (NRSA) Institutional Research Training Grant: (T32) *Individualized Care for At-Risk Older Adults,* NewCourtland Center for Transitions and Health and The Center for Integrative Science in Aging, NIH/NINR (T32-NR009356) University of Pennsylvania School of Nursing.