SHEEHY ANKLE FOOT CENTER

PAUL L SHEEHY, JR., DPM, Medical Director

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

PAUL L SHEEHY, JR., DPM, Medical Director

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:

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________