WELCOME TO SHEEHY ANKLE & FOOT CENTER OF TAMPA BAY

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

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: _____

Social Security #: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

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

Mailing Address (if different): _____

Sex: ☐ ☐ Age: _____ DOB: _____ Marital Status: ☐ ☐ ☐ ☐ ☐

MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED OTHER

Patient employed by: _____ Occupation: _____

May we call you at work? ☐ ☐ Work Hours: _____ Work Phone: _____

YES NO

Business Address: _____

Emergency Contact: _____ Relationship to patient: _____

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

How did you hear about us? _____

HEALTH INSURANCE INFORMATION

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

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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: _____

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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: _____

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 _____

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MEDICAL HISTORY

Check if you have had any of the following:

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

List any other medical problems:

Are you allergic/sensitive to:

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

List of surgeries: _____

List of medications you are currently taking, if any: