AMERICAN FOOT & ANKLE CLINIC OF TAMPA BAY

Today's Date: _____

Name: _____ **DOB:** _____

Sex: ____**Male** ____**Female** **Marital Status:** ____Single ____Married ____Widowed ____Divorced

SS#: ____-____-_____ **E-mail:**_____ Height_____ Weight_____

Spouse/Partner Name: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home #: ____-____-_____ **Cell #:** ____-____-_____ **Other #:** ____-____-_____

Employer: _____ **Phone:** _____-____-_____

Primary Insurance: _____ Are you the insured? ___Yes ____No

Insured Information

Subscriber Name: _____Relationship to insured: _____

Phone #: _____-____-_____ Policy ID: _____Group ID:_____

Secondary Insurance: _____ Are you the insured? ____Yes ____No

Insured Information

Subscriber Name: _____Relationship to insured: _____

Phone #: _____-____-_____ Policy ID: _____Group ID:_____

How did you find out about our practice? ____Physician _Internet _____Family member _____Friend

What is the reason for your visit today? _____

_____

How long has this bothered you? ____Days _____Weeks _____Months____Years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? __/10

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History and Physical

Current Medical Problems: _____

_____

Surgical History _____None

_____

_____

Social History

Do you drink alcohol?_____Yes _____No/Rarely _____Socially

Do you use recreational drugs: ___Yes ___ No; Do you smoke: ___Yes ___No ___Former Smoker

Current Medications

Name: _____Dose _____Name: _____Dose _____

Name: _____Dose _____Name: _____Dose _____

Name: _____Dose _____Name: _____Dose _____

Allergies _____No Known Allergies _____I am allergic to the following

_____Penicillin _____Shellfish _____Sulfa ____Tape ___Silver ___Ibuprofen ____Latex
_____Aspirin _____Betadine *(iodine)* ___TylenolTM ___Codeine Other:_____

Reaction *(specify):*_____

Family History Is there any family history *(blood relative)* of: *(Please check all that apply)*

Alzheimer's ___ Cancer___ Diabetes ___ High Blood Pressure ____ Arthritis ____
Blood Clot ___ Bleeding Disorders ____ Circulation Problems ____ Heart Disease____

Pharmacy Name: _____ **Address:** _____

Primary Care Physician: _____Date Last Seen: _____

Address: _____ City, State: _____

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Privacy Information Preferences

Can we send mail to the address on file?_____Yes

No Can we call the phone number on file? _____ Yes

No Can we leave voicemail on machine?

Yes _____No

PLEASE READ AND SIGN: The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____

Printed Name: _____