



Patient Information Sheet

Social Sec#: _____ Date: _____

Phone Number: _____ Cell Phone #: _____

Patient name: _____
Last Name First Name Middle Initial Age Birth Date

Sex (M or F) _____ Single O Widow O Married O Divorced O

Address: _____

City State Zip Code

What is your primary language spoken? _____

Occupation _____ Business Phone _____

Employer: _____

Address: _____

City State Zip Code

How did you hurt your foot: Work Auto accident Other

Do you have advanced directives :including living wills or durable powers of attorney for healthcare: _____

E-mail Address: _____

Family Doctor: First Name _____ Last Name _____

Phone _____

Whom may we thank for referring you to our office: _____

I give permission to South Florida Foot and Ankle Center to release any information requested by my insurance company and give South Florida and Ankle Center permission to perform general procedures in the diagnosis and/or treatment of my foot condition. I authorize payment of medical benefits to South Florida Foot and Ankle Center for services provided.

Patient/Guardian Signature

Date

Dr. Jonathan Cutler, DPM
Dr. Brett Fried, DPM
Dr. Julio C. Ortiz, DPM
Dr. Joshua P. Daly, DPM

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Please ask our staff to help you with this form if you would like assistance.

What is your foot or ankle concern? _____

How have you treated this problem at home? _____

Have you injured your feet before? If so how? _____

What type of work do you do? _____

Your Height _____ Weight _____ Shoe size/width _____

Have you had foot treatment before? _____ By whom? _____

Did anything disappoint you about your last visit to a foot specialist? _____

Have you had prior surgery on your foot and/or ankle? _____

What medications are you now taking? _____

Pharmacy Name _____ Pharmacy Phone Number _____

Pharmacy Address _____

Are you Pregnant? Yes No

Do you Smoke? _____ Amount per day? _____

Do you drink alcohol? _____ Amount per week? _____

To my knowledge, I am not allergic to any medications.

I am allergic to (please circle):

Aspirin Penicillin Novocain Sulfa Codeine Iodine/Shellfish Demerol
Adhesives/tape other



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Have you ever had or do you presently have any of the following:

Anemia.....Yes No Asthma..... Yes No

Arthritis.....Yes No Auto Immune Disorder... Yes No

Bleeding Tendencies.....Yes No Blood Clots..... Yes No

Cancer.....Yes No Diabetes.....Yes No

Glaucoma.....Yes No Gout..... Yes No

Heart DiseaseYes No Heart Murmur..... Yes No

Hepatitis.....Yes No High Blood Pressure.....Yes No

Kidney Disease.....Yes No Leg Cramps.....Yes No

Nervousness.....Yes No Numbness/Tingling.....Yes No

Rheumatism.....Yes No Stomach Ulcers.....Yes No

Any condition not mentioned _____

Any Family History of: High Blood Pressure Cancer Stroke Diabetes
Heart Disease Bleeding Disorders Blood Clots