SOUTH FLORIDA
FOOT & ANKLE CENTERS
www.sffac.com

Dr. Jonathan Cutler, DPM
Dr. Brett Fried, DPM
Dr. Joshua P. Daly, DPM, MBA
Dr. Jennifer Kazamias, DPM

Royal Palm Beach:
11412 Okeechobee Blvd.
Royal Palm Beach, FL 33411
Tel (561) 793-6170
Fax (561) 795-3683

Lake Worth:
3618 Lantana Rd.
Suite 102
Lake Worth, FL 33462
Tel (561) 967-4999
Fax (561) 967-2465

Palm Beach Gardens:
3375 Burns Rd.
Suite 107
Palm Beach Gardens, FL 33410
Tel (561) 691-4682
Fax (561) 624-7084

Belle Glade:
1100 S. Main Street
Belle Glade, FL 33430
Tel (561) 993-9968
Fax (561) 996-5970

Boynton Beach:
6699 Boynton Beach Blvd.
Suite 2B
Boynton Beach, FL 33437
Tel (561) 793-6170
Fax (561) 795-3683

Patient Information Sheet

Social Security Number _____ **Date** _____

Phone Number _____ **Cell Phone Number** _____

Last Name _____ **First Name** _____ **Middle Inital** _____ **Birth Date** _____

Sex ☐ **M** ☐ **F** ☐ **Single** ☐ **Widow** ☐ **Married** ☐ **Divorced**

Address _____

City _____ **State** _____ **Zip Code** _____

What is your primary language spoken? _____ **E-mail Address** _____

Occupation _____ **Business Phone Number** _____

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?

_____

Family Doctor:

First Name _____ **Last Name** _____ **Phone Number** _____

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** _____

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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? _____

Height _____ **Weight** _____ **Shoe Size/Width** _____

Have you had foot treatment before? ☐ Yes ☐ No 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** _____

Pharmacy Address _____

Are you Pregnant? ☐ Yes ☐ No

Do you Smoke? ☐ Yes ☐ No Amount per day? _____

Do you drink alcohol? ☐ Yes ☐ No Amount per week? _____

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

☐ I am allergic to:

☐ 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 Disease	☐ Yes	☐ 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