CITRUS PODIATRY CENTER, PA
PODIATRIC MEDICAL & SURGICAL CARE
EDWARD J. DALY, DPM*
ELLEN G. DALY, ARNP, ANP-BC**

Lecanto: 352-746-0077
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Mailing: P.O. Box 1120
Lecanto, FL 34460-1120

*Diplomat American Board of Podiatric Surgery
*Fellow American College of Foot & Ankle Surgery
*Diplomat American Academy of Wound Management
**American Nurses Credentialing Certification

PLACE NAME STICKER HERE

TODAYS DATE: _____

Name_____DOB_____

Sex: F M Marital Status: _____Single _____Married _____Widowed _____Divorced

Primary Language: _____ Race (Optional):_____Ethnicity (Optional):_____

Telephone Number: _____ Cell Number: _____

Email Address: _____

Permanent Address: _____

City: _____ State: _____Zip Code:_____

Seasonal Address: _____

City: _____ State: _____Zip Code:_____

*******ARE YOU ENROLLED IN HOSPICE OR LIVING IN A SKILLED NURSING FACILITY? YES_____NO_____**
IF YES, Hospice Name OR FACILITY NAME: _____
WHO CAN WE NOTIFY IN CASE OF AN EMERGENCY: NAME:_____

NUMBER:_____RELATIONSHIP:_____

Employed:Yes___No____ Retired: Yes___No_____If Employed: _____Full Time _____Part Time
If not Employed are you a student: _____Yes ____No
Employer: _____

Address: _____ City: _____

State: _____Zip Code:_____ Occupation: _____

How did you find out about our practice? CHECK ONE AND SUPPLY NAME OF REFERRAL
_____Phone Book _____WEBSITE_____Newspaper Ad _____Friend

_____Referral by Physician
Physician who referred you: _____

The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the provider and/or medical staff of any and all changes and updates to the information listed above.
Patient/Guardian Signature:

_____Date:_____ Revised 06/6/14

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Place Name Sticker Here

Do you have insurance? _____Yes _____No

Primary Insurance Name: _____

Are you the primary policy holder? _____Yes _____No

If you answered **No** please provide the following information:

Primary Policy Holders Name: _____

DOB: _____ SSN: _____

Secondary Policy Name: _____

Are you the primary policy holder for the secondary insurance? _____Yes _____No

If **No** please provide the following information:

Secondary Insurance policy holders name: _____

DOB: _____ SSN: _____

******PLEASE PROVIDE YOUR INSURANCE CARDS SO THAT WE MAY MAKE A COPY. A PICTURE ID WILL BE REQUIRED FOR SECURITY PURPOSES TO VERIFY YOUR IDENTIY.**

IF YOU DO NOT HAVE HEALTH INSURANCE WHO IS RESPONSIBLE FOR YOUR VISIT TODAY?

_____Self _____Spouse _____Parents (Only if minor child) Other: _____

If another individual is responsible please provide the following information:

Name: _____ Telephone/Cell: _____

Address: _____

City: _____State:_____Zip Code_____

DRIVERS LICENSE NUMBER (REQUIRED):_____

***CURRENT ADDRESS MUST MATCH ADDRESS ON DRIVERS LICENSE OR WE CAN NOT ACCEPT THIS PARTY AS PAYER**

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Patient/Guardian Signature:

_____Date:_____

Revised: 06/06/14

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Place Name Sticker Here

What is the reason for your visit today?

_____

_____

_____

_____

IS THIS A WORK RELATED INJURY OR A POTENTIAL PLANTIFF INJURY? YES NO

Have you seen a podiatrist in the past: _____Yes _____No The Date: _____

If Yes, the podiatrist name: _____

How long has this problem bothered you?

_____days _____weeks _____months _____years

What treatments have you tried and have they given you any relief?

_____

_____

_____

_____

Are you having pain? _____Yes _____No

If Yes, on a scale of 1-10 (1 being no pain and 10 being the worst please rate your pain):_____

Please describe the quality of your pain: __

_____burning _____constant _____dull _____sharp _____shooting _____throbbing

_____tingling or Other/describe: _____

****THE FOLLOWING INFORMATION IS REQUIRED**

Your Primary Care Physician Name: _____

City: _____ State: _____

The last visit date you had with you primary care physician: _____

The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the provider and/or medical staff of any and all changes and updates to the information listed above. I hereby give permission to any provider with this facility to administer treatment and to perform any and all procedures as deemed necessary in the diagnosis and/or treatment of my current or future condition.

Patient/Guardian Signature:

_____Date:_____

Revised: 06/06/14

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PLACE NAME
STICKER HERE

HEALTH INFORMATION

MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY TO YOU

_____Pre-Diabetic, Diabetic ____Hypertension _____Artificial Heart Valve _____Neuropathy _____Artificial Joint

_____History of Heart Attack or Stroke ____Circulatory Insufficiency _____History of Chronic Wounds _____Blood Clot _____Blood Disorders

_____HIV/AIDS _____Hepatitis B C _____Liver Disorder _____Kidney Disease _____Lung Disease

_____Arthritis _____Thyroid Disorder _____Stomach or Bowel Disorders _____High Cholesterol _____Cancer

_____Gout _____Alcoholism _____Depression _____Mental Health Disorders

ARE YOU PREGNANT? _____ ARE YOU NURSING? _____
ARE YOU UNDER THE CARE OF A PAIN MAINAGEMENT PHYSICIAN? YES/NO DR'S NAME: _____
IF DIABETIC YOUR LAST BLOOD GLUCOSE LEVEL: _____ LAST A1C_____DATE/TIME_____
LAST TETANUS SHOT/DATE_____LAST FLU VACCINE/DATE_____
HAVE YOU HAD A BLOOD TRANSFUSION PRIOR TO 1990? _____

SURGICAL HISTORY: PLEASE ANSWER ALL QUESTIONS

Have you ever had any surgery minor or major? YES NO
Please check all that apply: _____Heart _____Vascular _____ Orthopedic _____Liver _____Lung
_____Kidney _____Stomach/Bowels _____Gallbladder _____Pancreas _____Eye
Any other surgery not listed_____
HAVE YOU HAD ANY ANKLE OF FOOT SURGERY? YES NO
IF YES, PLEASE EXPLAIN; _____
_____
DATE OF SURGERY/S; _____

SOCIAL HISTORY: PLEASE ANSWER ALL QUESTIONS

Do you smoke? YES NO If yes, how many packs per day? _____ For how many years? _____
Do you drink alcohol? YES NO If yes how many drinks per day? _____ Drink of choice_____
Do you have or have you ever been treated for substance abuse? YES NO
Do you exercise? YES NO If yes, how many times per week? What type of activity?

MEDICATIONS: IF YOU HAVE A LIST PLEASE PROVIDE AND WRITE "SEE LIST"

Please provide all prescription, over the counter and supplements that you are currently taking;

MEDICATION NAME	DOSAGE	HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL ALLERGIES:_____
_____

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REVISED 06/06/14