Florida Foot and Ankle Group

[ ]Gary W. Chessman, DPM [ ] Luis J. Sanchez-Robles, DPM

Patient: **D.O.B** ________________

____
Last Name First Name M.I

Sex: [ ]M [ ]F

Address:

____

____
City State Zip Code

Phone:

____________________ ____________________ ____________________
Home Cell Work

Email: ____

____

Responsible Party (if a minor): ________________________________

Race	Ethnicity	Martial Status
[ ] Asian/Pacific Islander [ ] Black [ ] Native American/Alaskan [ ] White [ ] Unknown [ ] Other:________________	[ ] Hispanic [ ] Haitian [ ] Unknown [ ] Other:_______________	[ ] Married [ ] Divorced [ ] Separated [ ] Single [ ] Widowed [ ] Unknown

Emergency Contact:

Name: _______________________________

Relationship: _________________________

Phone: _______________________________

Primary Insurance

Name of Insurance:			Member ID:	
Address:				
City:	State:	Zip Code:	Group #	Relationship to Insured: [ ] Self [ ] Spouse [ ]Child [ ] Other:

Secondary Insurance

Name of Insurance:			Member ID:	
Address:				
City:	State:	Zip Code:	Group #	Relationship to Insured: [ ] Self [ ] Spouse [ ]Child [ ] Other:

Assignment of Benefits / Release Information

I hereby assign all insurance benefits to which I am entitles, including Medicare, Medicaid, private insurances, major benefits and any other health plans to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all the charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse, or psychiatric information which may be found in the record and is necessary to secure payment.

Patient or Responsible Party: ___________________________________ Date: _____________

Pharmacy Information

Name of Pharmacy:	Phone:		
Address:	City:	State:	Zip Code:

Reason for visit:

____

____

____

Primary Care Physician

Name:		Phone:		
Address:		City:	State:	Zip Code:

Smoking Status (Please circle one): Current / Previously / Never

Alcohol Use (Please circle one): Daily / Weekly / Socially / Rarely / Never

Past Surgical History

List any surgeries you have had and the date	
Surgery	Year

Patient Name:____ Date of Birth:_________________________________

Known Medication Allergies____

MEDICATIONS I TAKE (PRESCRIPTION, NON-PRESCRIPTION, VITAMINS, HERBALS)				
Medication Name	Dose	When I take it & How Many I Take	Doctor Who Prescribe Medication	Special Instructi

The accuracy of the information in this document depends on the accuracy and completeness of information provided by the patient at the time this document was prepared. The patient is responsible for advising the pharmacist of any change to these medications.

Patient Medical History

Please circle medial history that applies to you

Myocardial Infarction	Asthma
Congestive Heart Failure	Chronic Obstructive Pulmonary Disease
ANGINA	Peptic Ulcer Disease
Diabetes Miletus: Type 1 or Type 2	Thyroid Disease
High Blood Pressure	Arthritis
Hypercholesterolemia	Psychiatric
Stroke Syndrome	Depression
Transient Ischemic Attack	Tuberculosis
Cancer	AIDS

Other: ____

Please indicate which family member has or has had any history of the following illnesses.
Using the following (M) Mother (F) Father (B) Brother (S) Sister

High Blood Pressure	________	Thyroid Disorder	________
Alzheimer's Disease	________	Mental Illness	________
Parkinson's Disease	________	Asthma	________
Diabetes	________	Alcoholism	________
Obesity	________	Anemia	________
Coronary Artery Disease	________	Osteoporosis	________
Stroke	________	Multiple Sclerosis	________
Epilepsy	________	ADHD	________
Migraine	________	TB	________
Sickle Cell	________	COPD	________
Bleeding Disorders	________	Cancer	________
Lipid Disorder	________		

Patient Authorization for Use and Disclosure of Protected Health Information

I, ____________________________________ hereby authorize Dr. Gary W. Chessman

to use and/or disclose to my primary care physician/other parties. The following specific protected health information: Medical Records, Lab Results, X-Ray, Operative Reports, and any/all paperwork pertaining to Medical History of patient. I understand that this authorization is valid until we receive a written notice to discontinue. I understand that the purpose of the discloser I am granting is for medical reason only. I expressly acknowledge that this authorization is voluntary. I understand that I may see and copy the information described in this form if I ask for it. This form was completely filled in before I signed it. I certify that all my questions were answered to my satisfaction and that I understand this authorization from and all its contents. This authorization is valid of ____/____/____.

____	____
Name of Individual (Print)	Signature
____	____
Signature of Legal Representative	Relationship