

**FOOT & ANKLE ASSOCIATES OF NORTH NAPLES, PA**

*Greentree Professional Centre*  
10621 Airport-Pulling Rd. N. #4  
Naples, Florida 34109  
239 592-0700

**WELCOME TO OUR OFFICE**

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**LOCAL ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**HOME PHONE #:** \_\_\_\_\_ **WORK PHONE #:** \_\_\_\_\_

**SOCIAL SECURITY #:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**\*SEASONAL RESIDENTS: PLEASE LIST NORTHERN ADDRESS:** \_\_\_\_\_

\_\_\_\_\_  
**PRIMARY INSURANCE NAME:** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**INSURED'S ID / SS #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**PLACE OF EMPLOYMENT:** \_\_\_\_\_

**RELATIONSHIP TO INSURED ( CIRCLE ONE ) :** SELF SPOUSE CHILD OTHER

**HAVE YOU MET YOUR YEARLY DEDUCTIBLE ?** YES NO

**I authorize the release of medical information necessary to process this claim. I authorize and request payment of the insurance money to Foot & Ankle Associates of North Naples, PA.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**I accept full responsibility for all charges incurred for services rendered. I understand that all fees are payable at the time of service unless specific arrangements have been made prior to the visit. A \$15.00 fee will be charged to your account if appointments are not canceled at least 24 hours in advance.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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**PLEASE DESCRIBE THE PROBLEM YOU ARE HAVING:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
**HAVE YOU BEEN TREATED FOR THIS PROBLEM BEFORE?** YES NO

( OVER )

**IS YOUR PROBLEM WORK RELATED ?    YES    NO**

IF YES,    DATE OF INJURY : \_\_\_\_\_

**FAMILY PHYSICIAN'S NAME :** \_\_\_\_\_ **DATE OF LAST VISIT :** \_\_\_\_\_

**WHO REFERRED YOU TO OUR OFFICE :** \_\_\_\_\_

**PAST MEDICAL HISTORY ( CIRCLE ALL THAT APPLY )**

DIABETES ( INSULIN CONTROL / ORAL / DIET )	BACK PROBLEMS	ASTHMA
ARTHRITIS	VISION LOSS	SKIN PROBLEMS
HIGH BLOOD PRESSURE	HIV POSITIVE	ANEMIA
GOUT : LAST ATTACK _____	HEART DISEASE	MENTAL ILLNESS
HEARTBURN / GASTRIC ULCERS	HEARING PROBLEMS	CANCER : _____
HEPATITIS ( TYPE A , B OR NON AB )	BLEEDING PROBLEMS	ALCOHOLISM

**PLEASE INDICATE ANY MEDICAL PROBLEMS THAT ARE NOT LISTED ABOVE:**

\_\_\_\_\_  
**LIST ALL SURGERIES, TRAUMA OR HOSPITALIZATIONS YOU HAVE HAD:**

\_\_\_\_\_  
**SOCIAL HISTORY**

**MARITAL STATUS :**    SINGLE    MARRIED    DIVORCED    WIDOW

**SMOKER:**    YES    NO    # OF PACK PER DAY \_\_\_\_\_    # OF YEARS \_\_\_\_\_

**AVERAGE COFFEE / TEA / SODA INTAKE DAILY :**    \_\_\_\_\_    CUPS / GLASSES

**RECREATIONAL DRUG USE :**    YES    NO

**DO YOU PARTICIPATE IN ANY SPORTS ACTIVITIES REGULARLY ?    YES    NO**

( i.e. golf, tennis, walking, swimming )

**PLEASE LIST ACTIVITIES AND HOW OFTEN YOU DO THEM :** \_\_\_\_\_

\_\_\_\_\_  
**ALLERGIES ( CIRCLE ALL THAT APPLY )**

ADHESIVE TAPE	WOOL / NYLON	DAIRY PRODUCTS
SULFA DRUG	ASPIRIN	SEAFOOD
PENICILLIN	LOCAL ANESTHETIC	OTHER FOOD _____
METALS / JEWELRY	OTHER _____	
WHAT TYPE OF REACTION DO YOU HAVE ? _____		

**LIST ALL MEDICATIONS YOU ARE TAKING AT THIS TIME INCLUDING DOSAGE:**

\_\_\_\_\_  
\_\_\_\_\_