



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: \_\_\_\_\_

**Seasonal Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

**\*\*\*\*\*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:** \_\_\_\_\_

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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: \_\_\_\_\_ Occupation: \_\_\_\_\_

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How did you find 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 04/2014



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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: \_\_\_\_\_

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: \_\_\_\_\_



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**Place Name  
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What is the reason for your visit today?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IS THIS A WORK RELATED INJURY OR A POTENTIAL PLAINTIFF 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: \_\_\_\_\_



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**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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Date: \_\_\_\_\_

REVISED 04/2014