

# Foot and Ankle Associates

SINCE 1961

## Sports Medicine Center of Excellence

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*"We are pledged to improve the quality of life through comprehensive care of foot and ankle disorders.  
Our team is committed to a relationship based upon care, concern, and compassion."*

### Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Florida Address: \_\_\_\_\_  
Street (Apt. #) City State Zip

Northern Address: \_\_\_\_\_  
(Alternate) Street (Apt. #) City State Zip

S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  Male  Female Marital Status \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Facebook?  Yes  No Twitter?  Yes  No YouTube?  Yes  No

Employer: \_\_\_\_\_ Occupation & Position: \_\_\_\_\_

Are you a student?  Yes  No School \_\_\_\_\_ Grade Level \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's employer: \_\_\_\_\_

Who may we contact in case of Emergency? \_\_\_\_\_ Phone \_\_\_\_\_

**\*How were you referred to our office?**  Physician  Friend  Patient  Google  Website  Internet  TV  
 Florida Southern College  FitNiche  Detroit Tigers  Blog  Radio  Newspaper  
 Lakeland Runners Club  LPMC  Phone Book  Leadership Lakeland/Polk  Other \_\_\_\_\_

**\*Referral Source's Name?** \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Would you like a copy of your medical records from our office sent to your Primary Care Physician?  Yes  No

**\*Do you exercise more than twice a week?**  Yes  No *\*If yes, complete Sports Medicine History Form (Ask at Desk)*

Have you visited our website at: [www.floridafootandankle.com](http://www.floridafootandankle.com)?  Yes  No *\*If not, please visit for great info on foot and ankle conditions, our doctors, our practice, including YouTube videos, blogs, links, and much more!*

I certify that the information given above is true and correct.

I understand that it is my responsibility to notify Foot and Ankle Associates of any changes to the above information.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2929 S. Florida Ave. Lakeland, Florida 33803 863-687-3404

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## History & Medical Information

*When applicable fill-in all blanks, check, or circle all that apply*

1. Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Which foot/ankle/leg is worse: Right Left

2. What is your chief complaint with your foot, ankle, or leg? \_\_\_\_\_

3. When did pain/discomfort begin? \_\_\_\_\_ Has it: Improved Worsened or Stayed the same  
 Describe pain/discomfort (circle): Burning    Numbness    Sharp    Dull    other: \_\_\_\_\_  
 Rate your pain (circle): (no pain) 0    1    2    3    4    5    6    7    8    9    10 (worst pain)

4. What makes pain/discomfort better? \_\_\_\_\_

5. What makes pain/discomfort worse? \_\_\_\_\_

6. Has condition been treated? Yes No If yes, Explain: \_\_\_\_\_

7. Allergies: None  
Sulfa Drugs    Lidocaine    Tetanus    Anti-Inflammatories    Tape    Shellfish  
Codeine    Aspirin    Novocaine    Sutures    Metals    Other \_\_\_\_\_  
Penicillin    Iodine    Demerol    Radiographic Contrast/ Dyes

8. List all Medications/herbs/vitamins: None  
 Medication \_\_\_\_\_ mg \_\_\_\_\_ How often \_\_\_\_\_    Medication \_\_\_\_\_ mg \_\_\_\_\_ How often \_\_\_\_\_  
 Medication \_\_\_\_\_ mg \_\_\_\_\_ How often \_\_\_\_\_    Medication \_\_\_\_\_ mg \_\_\_\_\_ How often \_\_\_\_\_  
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 Medication \_\_\_\_\_ mg \_\_\_\_\_ How often \_\_\_\_\_    Medication \_\_\_\_\_ mg \_\_\_\_\_ How often \_\_\_\_\_

\*What is the name/location of your Pharmacy? \_\_\_\_\_ Phone # \_\_\_\_\_

9. Past Medical History: None  
Anemia    Gout    Kidney Disease    Other Arthritis  
Bleeding Disorders    Heart Disease    Lung Disorders    Prostate Disorders  
Cancer    Hepatitis    Mitral Valve Prolapse    Rheumatic Fever  
Diabetes    High Cholesterol    Nerve Disorders    Thyroid Disorders  
Epilepsy    HIV/ Aids    Neurologic    Stroke  
Osteoarthritis    High Blood Pressure    Other \_\_\_\_\_

10. Surgical History: None  
 Surgery/Date/Location: \_\_\_\_\_ Surgery/Date/Location: \_\_\_\_\_  
 Surgery/Date/Location: \_\_\_\_\_ Surgery/Date/Location: \_\_\_\_\_  
 Surgery/Date/Location: \_\_\_\_\_ Surgery/Date/Location: \_\_\_\_\_  
 Surgery/Date/Location: \_\_\_\_\_ Surgery/Date/Location: \_\_\_\_\_

11. Family History: None  
Diabetes    Heart Disease    Bleeding Disorders    Mental Illness  
High Blood Pressure    Stroke    Kidney Disease    Cancer  
Rheumatology    Foot Problems    Other Family History: \_\_\_\_\_

12. Social History: Are you: Pregnant Nursing  
 Tobacco Use? Yes No If yes how much? \_\_\_\_\_ Have you ever smoked? Yes No  
 Chewing Tobacco? Yes No If yes how much? \_\_\_\_\_ Caffeine Use? Yes No  
 Alcohol Use? Yes No If yes how much? \_\_\_\_\_ Drug Use (recreational, IV)? Yes No  
 \*Exercise Regularly? Yes No If yes, how many hours per week? \_\_\_\_\_

*\*The American College of Sports Medicine (ACSM) recommends a minimum of 30 minutes exercise on 5 days per week.*

## Review of Systems

*Check all that apply*

- 1. Constitutional Symptoms:**  None  
 Fever/Chills                       Sweats                       Weight Loss
- 2. Cardiovascular:**  None  
 Chest Pain/Heart Attack               Congestive Heart Failure               Leg Pain w/ Exercise  
 Heart Murmur Palpitations               Swelling in Legs/Ankles               Cardiovascular Surgery
- 3. Endocrine:**  None  
 Often Thirsty                       Often Urinating                       Kidney Disease                       Pancreatitis  
 Thyroid Disorder                       Diabetes Mellitus                       Prostate Problems
- 4. Head, Eyes, Ears, Nose and Throat:**  None  
 Contacts                       Eyeglasses                       Dentures                       Double Vision  
 Cataracts                       Dizziness                       Ringing in Ears                       Neck Pain  
 Sore Throat                       Nose Bleeds                       Difficulty Swallowing
- 5. Gastrointestinal:**  None  
 Nausea                       Vomiting                       Diarrhea                       Constipation  
 Stomach                       Ulcers                       Decrease in Appetite                       Blood in Stool  
 Hepatitis                       Acid Reflux
- 6. Integumentary:**  None  
 Rash                       Skin Ulcers                       Lesions                       Sensitivity to Sun  
 Change in Skin Color                       Growth on Skin                       Recurrent Infections                       Eczema  
 Cracking of the Skin                       Keloid                       Hair Loss
- 7. Hematological/Lymphatic (blood):**  None  
 Bleeding abnormalities                       Anemia Lump in Groin or Armpit Lymphoma                       Swollen Glands
- 8. Musculoskeletal:**  None  
 Tendonitis                       Broken Bones                       Arthralgia                       Weakness Of limbs  
 Feeling Weak                       Joint Pain                       Bursitis
- 9. Nervous System:**  None  
 Migraines                       Seizures                       Strokes                       Nervous Disorders  
 Ataxia (loss of balance)                       Aphasia                       Loss of speech                       Confusion  
 Neuropathy (loss of sensation)                       Speech Difficulties                       Fainting
- 10. Psychiatric:**  None  
 Nervousness                       Tension                       Depression
- 11. Respiratory:**  None  
 Shortness of Breath                       Emphysema                       Cough Bronchitis                       Wheezing  
 Difficulty Breathing                       Asthma                       Previous Pulmonary Disease  
 TB (tuberculosis)                       Pneumonia                       Exposure or Treatment

**12. Is there anything else we should know?**

**To the best of my knowledge, the questions on this form have been accurately answered.  
 I understand that providing incorrect information can be dangerous to my health.**

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Insurance Policies and Privacy Practices

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Patient Name: \_\_\_\_\_

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

Insured's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insured's Relationship: \_\_\_\_\_

- 1. I request that payment of authorized insurance benefits be made on my behalf to Foot and Ankle Associates. I authorize any holder of medical information about me to be released to my insurance company any information needed to determine these benefits for related service. I also accept responsibility for any deductible, percentage, co pay, or non-covered items, out of network penalties or collections costs that I may encounter. \_\_\_\_\_ **(Initial)**
- 2. I understand that the Foot & Ankle Associates will bill my secondary insurance ONE TIME as a COURTESY. If payment has not been received within 45 days the balance will be my responsibility. \_\_\_\_\_ **(Initial)**
- 3. I understand that it is my responsibility NOT the Foot & Ankle Associates for knowing if they are a participating provider with my insurance company, I also understand that I am responsible for obtaining any required referrals and will be held responsible for charges not paid due to failure to obtain said referral. \_\_\_\_\_ **(Initial)**
- 4. I will be paying my co-pays/deductibles or anything not covered by my insurance by:  
Cash Check Credit Card
- 5. There is a \$30 fee for all returned checks and a \$25 fee if I do not give 24 hour notice for cancellations. \_\_\_\_\_ **(Initial)**
- 6. Acknowledgement of **HIPPA** Guidelines (Notice of Privacy Practices)  
 I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. \*\*  
\*\*HIPPA packets are available at the front window. \_\_\_\_\_ **(Initials)**
- 7. With whom may we leave a message if you are unable to answer:  
Patient only Patient/Spouse Anyone answering the phone
- 8. May we leave lab, testing results, appointment reminders & surgical procedure dates on your answering machine/voice mail? YES NO
- 9. Whom may we share your health information if you are unavailable?  
**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_
- 10. I hereby give permission to Drs. Odro, Fazekas, and Werd, to treat my lower extremity condition.

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_