Dr. George N. Merritt
Dr. Russell W. Rowan
Dr. Bryan A. Spooner
Dr. Robert S. Pearson

Patient Information

Name (Last, First, M.I.):____

If Minor, (Parent/Guardian):________________________________

Address: ________________________ Apt: ______ City, State Zip: ____________

Phones: (Home) ______________ (Cell) ______________ (Work) ______________

Age: _____ DOB: ___________ Gender: M F SSN: _________________

Race: __________ Ethnicity: _______ Primary Language: _______________

Marital Status: Married Single Widowed Divorced Separated Email: ______________________

Employer: _________________ Occupation: _____________ *If Student,* Full Time ____ Part Time ____

Spouse's Name: _____________________ Spouse's Employer: _________________

Phones: (Cell) ____________ (Work) __________ Occupation: _________________

Emergency Contact (Name/Relationship): __________________ *Phone:* ________________

Insurance Information

Primary Insurance: ____

Policy No.: _______________________ Group No.: _____________

Subscriber (Name/Relationship): _______________________ (DOB) ______________

Subscriber's (Address) ______________________ (SSN) _______________

Subscriber's Phones: (Home) __________________ (Work) __________________

Secondary Insurance: ____

Policy No.: _______________________ Group No.: _______________

Subscriber (Name/Relationship): _______________________ (DOB) _____________

Subscriber's (Address) ______________________ (SSN) _______________

Subscriber's Phones: (Home) __________________ (Work) __________________

Who may we thank for referring you to our office? _________________________

Please note: Payment for services is required at the time services are rendered unless prior arrangements have been made in advance. Regardless of insurance, ultimately, the patient or guarantor is responsible for all charges incurred. Also, some insurances may require prior authorization for services. Should this pertain to you, please verify with our receptionist to ensure this approval has been obtained *before* being seen by one of our physicians.

*****CONTINUE TO NEXT PAGE*****

TALLAHASSEE PODIATRY ASSOCIATES, P.A.
We heal soles.

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Medical & Podiatric Information

Primary Care Physician: ___________________________________ City, State: __________________________ Date last seen: ___________

Previous Podiatrist: ____ Date last seen: ________________

Health History

(Check conditions that apply to you)	Yes	No			Yes	No
Diabetes				Mental Disorder		
Arthritis				Anemia		
High Blood Pressure				Tuberculosis		
Heart Disease				Circulation Problems		
Kidney Disease				Peripheral Vascular Disease		
Liver Disease				Bleeding Disorders		
HIV				Phlebitis		
Lung Disease				Blood Clots		
Thyroid Disease				Varicose Veins		
Neurologic Disease				Stroke		
				Cancer *(Including Skin)* Type: _________		

If any relatives (be specific) have or had any of the conditions listed above, please describe: _________________________________

____

Are you pregnant? Yes ____ No ____ *If yes, due date:* ___________ Are you breastfeeding? Yes ____ No____

Alcohol Use? Yes ____ No ____ *If yes, how much?:* ______________ Recreational drugs use? Yes ____ No ____

Tobacco Use? Yes ____ No ____ *If yes, how much and duration?:* ____________________

Have you been hospitalized in the past year? Yes _____ No _____ If yes, list the reason below: ________________________________

____

Are you taking medications *(List ALL)*? Yes _____ No _____ If yes, list them below: ____

____

Do you have allergies? Yes _____ No _____ If yes, list them & reactions below: ____

____

Preferred Pharmacy (Include Phone & Location): ____

Surgeries *(list all, including foot, ankle, & vascular)*: ____

____

Reason for Visit *(Please specify about the nature, location, & duration of condition)*: ____

____

Is this work or auto related?: Yes ____ No ____ If yes, give date of injury: _________________

Patient's Signature: ____ Date: _______________________

Parent/Guardian's Signature: ____ Date: _______________________

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