

**THE FOOT AND ANKLE INSTITUTE OF SOUTH GEORGIA, P.C.**



Nic Dodson, DPM  
Erin Dodson, DPM  
Phone Number: 229-244-0070  
Fax Number: 229-244-0080  
4370 Kings Way Suite B  
Valdosta, GA 31602  
www.faisouthgeorgia.com

**PATIENT GENERAL INFORMATION**

Name (Last, First, Middle): \_\_\_\_\_

Sex: M F Age: \_\_\_\_ Birthdate: \_\_/\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address (Street, City, State, Zip): \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cellular Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Business Phone #: \_\_\_\_\_

Business Address (Street, City, State, Zip): \_\_\_\_\_

Marital Status: S M W D Spouse's Full Name: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Spouse's Business Phone #: \_\_\_\_\_ Spouse's Cellular Phone #: \_\_\_\_\_

Guarantor of Patient's (Responsible party/Parent) Full Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Guarantor's Address: \_\_\_\_\_

Guarantor's Home Phone #: \_\_\_\_\_ Guarantor's Occupation & Employer: \_\_\_\_\_

Guarantor's Business Phone #: \_\_\_\_\_ Guarantor's Cellular Phone #: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Company: \_\_\_\_\_ Secondary Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber Birthdate: \_\_/\_\_/\_\_\_\_ Subscriber Birthdate: \_\_/\_\_/\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

**TODAY'S VISIT:** What is the specific reason for your appointment today? \_\_\_\_\_

How did you hear about our office? Please circle all that apply: Doctor Referral   Yellow Pages   Newspaper Ad  
Website   Health Fair   Family Member/Friend Referral   Other: \_\_\_\_\_

**ACCIDENT INFORMATION:** Is your visit today related to a work or auto accident? Yes   No

If yes, is the accident related to work or auto? Please check one. (   ) Work   (   ) Auto

Date of accident/injury: \_\_\_/\_\_\_/\_\_\_\_   Brief Description: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Were you seen in the hospital?   Yes   No   Date seen in the ER/Hospital: \_\_\_\_\_

Responsible Party for Payment (Full Name): \_\_\_\_\_

(Address): \_\_\_\_\_

(Phone #): \_\_\_\_\_   Claim #: \_\_\_\_\_

**EMERGENCY INFORMATION:** In case of emergency, who would like us to notify?:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**MEDICAL INFORMATION:**

Primary Care Physician's Name (First and Last): \_\_\_\_\_

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

Primary Care Physician's Address: \_\_\_\_\_

Date that you were last seen by your primary care physician? \_\_\_\_\_

**Allergies (if yes, please include type of reaction):**

(Drugs): \_\_\_\_\_

(Food): \_\_\_\_\_

(Other): \_\_\_\_\_

**Current Medications (including vitamins, herbals, and over the counter medications):**

(Name, How Much?, How often?) \_\_\_\_\_

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

**Past Medical History/Known Medical Conditions (Please Circle All That Apply):**

Measles	Venous Disease	Asthma	Kidney Disease
Mumps	Arterial Disease	Emphysema	Gout
Chicken Pox	Anemia	Tuberculosis	Rheumatoid Arthritis
Rheumatic Fever	Heart Attack	Chronic Headaches	Osteoarthritis
Scarlet Fever	Blood Clots	Glaucoma	Osteoporosis
Polio	Enlarged Heart	Cataracts	Lupus
Diabetes Mellitus	Congestive Heart Failure	Acid Reflux	Seizure Disorders
Thyroid Disease	Heart Murmurs	Stomach Ulcers	Sickle Cell Disease/Trait
Hypertension	Heart Valve Disease	Diverticulitis	Cancer
High Cholesterol	Pacemaker	Gallbladder Disease	Fractures
Stroke	Urinary Tract Infections	Prostate Disease	Liver Disease / Hepatitis

**Previous Surgeries (including dates and surgeon's name):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any problems with anesthesia in the past? Yes No If yes, what happened? \_\_\_\_\_

Tobacco Use: Yes No If so, how much and for how many years? \_\_\_\_\_

Alcohol Use: Yes No If so, how much and for how many years? \_\_\_\_\_

Street Drug Use: Yes No If so, what kind, how often? \_\_\_\_\_

**Family History of Any Medical Conditions:**

(Father): \_\_\_\_\_

(Mother): \_\_\_\_\_

(Brother): \_\_\_\_\_

(Sister): \_\_\_\_\_

**Please circle any of the following conditions/symptoms that you have recently experienced or are currently experiencing now:**

- |                              |                            |                             |
|------------------------------|----------------------------|-----------------------------|
| Concussions                  | Laryngitis                 | Diarrhea                    |
| Dizziness                    | Loss of speech             | Constipation                |
| Loss of consciousness        | Tonsillitis                | Weight Gain                 |
| Blurred Vision               | Difficulty Swallowing Food | Weight Loss                 |
| Blindness                    | Chest Pain                 | Jaundice                    |
| Double Vision                | Shortness of Breath        | Difficult/Painful Urination |
| Decreased or Loss of Hearing | Leg Cramps                 | Increased Urination         |
| Ringing in the Ears          | Bronchitis                 | Blood in Urine              |
| Chronic Earaches             | Pneumonia                  | Blood in Stool              |
| Sinus Problems               | Nausea                     |                             |
| Nasal Polyps                 | Vomiting                   |                             |

**For Females Only:** Are you currently pregnant? Yes No

How many pregnancies have you had? \_\_\_\_\_ How many births have you had? \_\_\_\_\_

Any difficulty with menstruation? Yes No Have you gone through menopause? Yes No

**Please list any past medical problems, conditions, or diseases or current medical symptoms not previously mentioned in this paperwork:** \_\_\_\_\_

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