Charles D. Ganime, DPM, FACFAS, CWS

Diplomate, American Board of Podiatric Surgery
Diplomate, American Academy of Wound Management

Patient Information Sheet (Confidential)

Name: _____ **Date of Birth**: _____ **Age**: _____

Address: _____
Street Apt # City State Zip

S.S.#: _____-_____-_____ **Sex**: ❒ M ❒ F **Primary Doctor**: _____

Phone #: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Email Address (Please print): _____

Marital Status: ❒ Single ❒ Married ❒ Widow ❒ Divorced ❒ Other

Ethnicity*: ❒ Non-Hispanic Origin ❒Hispanic Origin

Race*:
❒ African or African-American
❒ Asian or Asian American
❒ Caucasian or European American
❒ Native American or Native Alaskan
❒ Native Hawaiian or Other Pacific Islander
❒ Other Race: _____

Preferred Language: ❒ English ❒ Other language: _____

Employment: ❒ Full-time ❒ Part-time ❒ Student ❒ Retired ❒ Other _____

Employer: _____ **Occupation**: _____

Primary Pharmacy: _____
Name of Pharmacy City

Responsible Party/ Primary Insurance Carrier (If Not Self)

Name: _____ **Date of Birth**: _____

Relationship to the patient: _____ **Sex**: ❒ M ❒ F

If required for insurance submission: S.S.#: _____ - _____ - _____

What is the foot or ankle problem for which you came to be treated? _____
_____

How were you referred to our office? _____

*It is required by the government that we ask these questions in accordance with the US Office of Management and Budget Policy Directive No. 15.

I certify that the information given above is true and correct. I understand that it is my responsibility to inform the office of Dr. Charles D. Ganime, DPM of any changes to the above information.

Patient or Guardian Signature: _____ **Date**: _____