Patient Information & Health Record

In order to help us render the proper podiatric services to you, please complete this form entirely.
We thank you for you cooperation.

DATE: ____________________________ SOCIAL SECURITY NO:______/_____/_____ SEX M / F

NAME:___________________________________ Marital Status: ____ Date of Birth ____/____/______
(If patient is minor, please fill with responsible party information).
Name:________________________________ HOME PHONE:(____)______-_______

ADDRESS:________________________________ CITY: ______________ STATE: ____ ZIP: ________

WORK PHONE:(____)______-_________ extension:_____ CELL PHONE:(_____)______-_________

EMAIL ADDRESS: ____

EMPLOYER:____ OCCUPATION:__________________

EMPLOYER'S ADDRESS: _____________________ CITY: _____________ STATE: ____ ZIP: _______

SPOUSE'S NAME:____________________ Date of Birth: ___/___/___ Work Phone: (___)____-______
(Or if a child, responsible parent's name)
IN CASE OF EMERGENCY, CONTACT:___________________________ Phone: (___)____-______

NEAREST FRIEND OR RELATIVE: _______________________________ Phone: (___)____-______
(not living with you)
FAMILY PHYSICIAN: ____ Phone: (___)____-______
If Medicare Patient – Date Last Seen by Your Primary Care Physician: _________________________

PRIMARY INSURANCE INFORMATION

NAME OF CARD HOLDER: ________________________________ Relationship to Patient: _________

NAME OF INSURANCE COMPANY: ____

INSURANCE ADDRESS: ______________________ CITY: ____________ STATE: _____ ZIP: _______

INSURANCE PHONE: (___)____-______ EMPLOYER OF CARD HOLDER: _____________________

POLICY NUMBER ON CARD: _______________________ GROUP NUMBER (if any): _____________
(Including any prefixed- ex. "XWG", "R", "C", without them your claim will be rejected by your insurance co.)
DATE OF BIRTH OF CARD HOLDER: _______/_______/_______

SECONDARY INSURANCE INFORMATION

NAME OF CARD HOLDER: _______________________________ Relationship to patient: __________

NAME OF INSURANCE COMPANY: ____

INSURANCE ADDRESS: ______________________ CITY: ____________ STATE: _____ ZIP: _______

INSURANCE PHONE: (___)____-______ EMPLOYER OF CARD HOLDER: _____________________

POLICY NUMBER ON CARD: ________________________ *GROUP NUMBER (if any):*
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