ANKLE & FOOT CLINIC, PS
PATIENT INFORMATION FORM

Personal Information Nick Name: _____

PLEASE PRINT

Patient Name: _____ Birth Date: _____ Sex: M /F
Last , First, Middle name

⇒Home Address: _____ Apt/Unit # _____(if applicable)

City: _____ State: _____ Zip: _____

⇒ Mailing/Billing Address: _____ If applicable PO Box _____

Apt/Unit # _____(if applicable) City: _____ State: _____ Zip: _____

Home #:(_____) _____-_____ **Work** #:(_____) _____-_____ **Cell** #:(_____) _____-_____

E-mail: _____ Patient Social Security No# _____

Please only choose one ***Please only choose one***

***Preferred Phone:** ☐ Home ☐ Cell ☐ Work *Preferred form of contact: ☐ Phone ☐ Mail

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

***Ethnicity:** _____ ***Race:** ☐ American Indian/Alaska Indian ☐ Black/African American

***Primary Language:** _____ ☐ Hispanic ☐ Pacific Islander ☐ White ☐ Asian ☐ More then one race

Primary Care Doctor: _____ **Diabetic Doctor**: _____

Name of clinic: _____ **Name of clinic:** _____

Last date seen by Primary Doctor: ____/____/____ Last date seen by Diabetic Doctor: ____/____/____

Who referred you to us? _____

***Pharmacy**: _____ Location: _____ Phone #: (_____) _____-_____

Emergency Contact (1) first & last name: _____ Relationship: _____

Phone #:(_____) _____-_____ Birth Date: ____/____/____ **Do they live with the patient?** Yes / No

Emergency Contact (2) first & last name: _____ Relationship: _____

Phone #:(_____) _____-_____ Birth Date: ____/____/____ **Do they live with the patient?** Yes / No

- (***Must fill out if patient is a minor***) Do you have a legal guardian (**parent**) or healthcare power of attorney?

if yes, Name (first & last):_____ Birth Date: ____/____/____ Phone #:(_____) _____-_____

Home Address: _____ Apt# _____City/State: _____ Zip: _____

-Insurance Information- ***REQUIRED TO BILL YOUR INSURANCE****

Primary Insurance:

Insurance Name:_____Relationship to patient: _____

Subscriber Name:_____ Birth Date: ____/____/____ Phone #:(_____) _____-_____

Home Address: _____ Apt# _____City/State: _____ Zip: _____

Secondary Insurance:

Insurance Name:_____Relationship to patient: _____

Subscriber Name:_____ Birth Date: ____/____/____ Phone #:(_____) _____-_____

Home Address: _____ Apt# _____City/State: _____ Zip: _____

Date: ___/___/___ MR:_____ Entered by:_____