PATIENT INFORMATION FORM

Name Last: _____ First: _____ MI: _____

Mailing Address: _____

City: _____ St: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____

Date of Birth: _____ Age:_____Race:_____Ethnicity:_____

Email Address:_____Social Security # _____

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

MAY WE LEAVE APPOINTMENT INFO VIA TEXT MESSAGE? __YES __NO

Whom may we contact in case of emergency? _____Day Phone: _____

Preferred Pharmacy:_____

Primary Physician:_____Phone:_____Clinic:_____

SPOUSE OR RESPONSIBLE PARTY (if different from above)

Name Last: _____First:_____ MI: _____

Date of Birth: _____ Male Female

Mailing Address: _____

City:_____State:_____ Zip:_____ Phone:_____Cell:_____

PRIMARY INSURANCE NAME:_____

Insured'sName:_____BirthDate:_____SS#:_____

PolicyNumber:_____Group#:_____

Policy Holders Relationship to you _____Employer:_____

Address if different than yours_____

SECONDARY INSURANCE NAME:_____

Insured'sName:_____BirthDate:_____SS#:_____

PolicyNumber: _____Group#_____Relationship to policy holder_____

Are you interested in access to the patient portal online? If so, please provide us an email address, and we will send you an invitation. YES _____ NO_____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all information on this sheet and have completed the above answers. I authorize the release of medical or other information necessary to process my claims. I give my permission to Dr. Howard or Dr. Matthews to administer treatment, x-ray and photograph my feet, and to perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my feet on my approval.

Signature_____
Date_____

Parent (if patient is a minor) _____ Date_____