Family Foot Center

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Physical Address: _____ Mailing (if different) _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender
□ Male
□ Female

Marital Status
□ Single □ Married
□ Seperated/Divorces
□ Widow/er
□ Domestic Partner

Race
□ White/Caucasian □ Black/African American
□ Native Hawaiian/Other Pacific Islander
□ Asian □ American Indian or Alaska Native
□ Other _____

Ethnicity
□ Hispanic or Latino
□ Not Hispanic or Latino

Birthdate: _____ Soc Sec#: _____

Employed
□ Full Time □Part Time □Retired

E-mail: _____ ☐ I would like to receive correspondence via e-mail.

Primary Care Physician _____ Location _____

Pharmacy _____ Location _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Insurance Information

Ins Co Name: _____

ID# _____ Group# _____

Subscriber Name _____

Birthdate _____ Relationship _____

Employer _____

Employer Phone #: _____

Secondary Insurance Information

Ins Co Name: _____

ID# _____ Group# _____

Subscriber Name _____

Birthdate _____ Relationship _____

Employer _____

Employer Phone #: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ SocSec#: _____ Drivers Lic: _____

Release of Benefits Information:

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctors' office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-pays, deductables and non-covered services. I authorize the release of information required to procss my claims. (If not signed, payment in full due at time of service.)

ALL CO-PAYS ARE DUE AT TIME OF SERVICE.

Do we have permission to : Leave a detailed message on your answering machine ☐ Yes ☐ No

Leave a brief message for a call back with any member of your household ☐ Yes ☐ No

Leave a message at your place of employment ☐ Yes ☐ No

May be discuss your medical condition with a member of your household ☐ Yes ☐ No

If yes, whom? _____ Relationship: _____

Patient Signature: _____ Date: _____

Parent or Authorized Respresentative (if applicable): _____