

FAMILY PODIATRY ASSOCIATES, P.C.

NAME _____

ADDRESS _____ APT. # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK _____ CELL _____

PATIENT'S SOCIAL SECURITY # _____ - _____ - _____ AGE _____

DATE OF PATIENT'S BIRTH _____ EMAIL ADDRESS _____

NAME OF HEALTH INSURANCE _____ POLICY # _____

NAME OF POLICY HOLDER _____

POLICY HOLDER'S BIRTH DATE: _____ S.S.# _____

NAME OF SECONDARY INSURANCE _____ POLICY # _____

WHO'S NAME IS THE SECONDARY INSURANCE UNDER _____

S. S. NUMBER OF THAT PERSON _____

DATE OF BIRTH OF THAT PERSON _____

PRIMARY MEDICAL DOCTOR _____ PHONE _____

LIST ALLERGIES TO MEDICATION _____

LIST ALL MEDICATION _____

LIST ALL MEDICAL PROBLEMS OF PATIENT _____

DO YOU HAVE HEPATITIS _____

WHAT IS THE SPECIFIC REASON FOR THE VISIT _____

HOW DID YOU HEAR ABOUT THE OFFICE _____

I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF ALL CO-PAYS AT THE TIME OF THE VISIT AS WELL AS DEDUCTIBLES AND ANY CO-INSURANCE YOUR INSURANCE CARRIER STATES YOU OWE.

SIGNATURE _____ DATE _____