

New Patient Form

PATIENT'S PERSONAL INFORMATION

Name	Date	
Address	City	Zip
Home Phone	Age	Birth Date
Social Security Number	Marital Status	
Employer	Work Phone	
Family Doctor	Phone	Last Visit
Emergency Contact	Relationship	
How did you hear about our office?		

SPOUSE INFORMATION

Spouse Name	Birth Date
Employer	Work Phone
Social Security Number	

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Name	Relationship	
Address	City	Zip
Home Phone	Work Phone	Birth Date
Social Security Number		

FOR YOUR INFORMATION

HMO patients must have a referral form from their primary care physician.

We accept Medicare assignment and will submit to your supplemental insurance.
Any deductible and patient portion is your responsibility.

We will submit commercial insurance for you. Payment is expected for the initial office visit.

SIGNATURE

I hereby give permission to Dr. _____ to administer treatment and perform such general procedures as they may deem necessary in the diagnosis and/or treatment of my foot condition.

The Foot Clinic is not a group. All physicians operate independant practices located at 1226 W. Taylor Street.

Signature _____ Date _____