

## New Patient Information

### Please Print

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
          First                    Middle                    Last

Sex    Male \_\_\_\_ Female \_\_\_\_ Race \_\_\_\_ Married \_\_\_\_ Single \_\_\_\_ Widowed \_\_\_\_ Divorced/Separated \_\_\_\_

Home Address \_\_\_\_\_ Apt No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security No. \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Patient Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

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(If patient is a child or dependent adult, please give name of responsible party for finances and billing)

Responsible Party \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Responsible Party Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

( ) Check here if NO health insurance

Primary Carrier \_\_\_\_\_ Group or ID No. \_\_\_\_\_

Policy Holder (if other than patient) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Secondary Carrier \_\_\_\_\_ Group or ID No. \_\_\_\_\_

Were you referred to this office? By Whom? \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

Is this a compensation or work-related case? Yes \_\_\_\_ No \_\_\_\_ Date of Accident \_\_\_\_\_

**Briefly describe foot problem:** \_\_\_\_\_

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I hereby give the above named doctor permission to administer the necessary treatment in order to diagnose and treat my present foot condition, after it has been explained to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_