PREMIER
FOOT & ANKLE CARE

Today's Date: _____/_____/_____

New Patient: YES NO

Please provide your ID & all insurance cards to the front desk.

PATIENT INFORMATION:

Full Name:_____ **Age**:____

Address:_____ **City**:_____ **State**:___ **Zip**:_____

Date of Birth:_____/_____/_____ **SS#**:_____-_____-_____ **Gender**: M F

Home Phone: ( )_____ **Cell Phone**: ( )_____ **Work Phone**: ( )_____

E-Mail Address:_____

Emergency Contact:_____ **Relationship**:_____ **Phone**: ( )_____

Please circle below:

Marital Status: Single Married Divorced Widowed

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Race: Asian American Indian or Alaska Native African American Hispanic White Hawaiian or Pacific Islander

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INSURANCE INFORMATION:

Primary Insurance:_____

Subscriber Name:_____ Subscriber DOB:_____/_____/_____

Patient Relationship: Self Spouse Parent Other

Secondary Insurance:_____

Subscriber Name:_____ Subscriber DOB:_____/_____/_____

Patient Relationship: Self Spouse Parent Other

Employer:_____ **Employer Phone**: ( )_____

ADDITIONAL INFORMATION:

Pharmacy Name:_____ **Pharmacy Phone**: ( )_____

Pharmacy Address:_____

How did you hear about us?

Physician Family/Friend Website/Google Facebook/Instagram ER/Urgent Care

Whom may we thank for your referral? _____