FOOT & ANKLE SPECIALISTS of DELAWARE COUNTY

Patient Name: _____ **Social Security #:** _____
First MI Last

Home Address: _____
(Street) (City) (State, Zip Code)

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

Marital Status: circle: (Single) (Married) (Divorced) (Separated) (Widow(er)) **Primary Language Spoken**: _____

Date of Birth: _____ **Age:**_____ **Gender**: circle: (Male) or (Female)

Ethnicity: circle: (Hispanic/Latino) or (Not Hispanic/Latino) **E-mail**:_____

Race: choose most appropriate one: (White) (American Indian) (Asian) (Black or African American) (Pacific Islander)

If Patient is a Minor (under18), Name of Parent or Guardian: _____

Patient's Employer:_____ **Occupation**: _____

Employer's Address: _____
(Street) (City) (State, Zip Code)

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

Spouse/Partner Name:_____ **DOB**:_____ **Soc. Sec. #**_____

Spouse/Partner Employer:_____ **Spouse/Partner Work Phone**:_____

Spouse/Partner Employer Address:_____
(Street) (City) (State, Zip Code)

Family Doctor: _____ **Phone Number**: _____ **Last Visit**: _____

Referred to Our Office by: _____ **Reason for Visit to our Office** : _____

Does patient smoke? circle one: (every day) (some days) (used to but quit) (never)

Height_____ Weight_____ Most Recent Known Blood Pressure_____/_____

Pharmacy Name & Phone #_____

PRIMARY INSURANCE: _____ ID#: _____

Name of Policyholder: _____ Relation to Patient: _____

Policyholder's Social Security No: _____ Policyholder's Date of Birth: _____

Policyholder's Address:_____

SECONDARY INSURANCE: _____ ID#: _____

Name of Policyholder: _____ Relation to Patient: _____

Policyholder's Social Security No: _____ Policyholder's Date of Birth: _____

Policyholder's Address: _____

SIGNATURE:_____ **DATE:**_____