FIRST STATE FOOT & ANKLE, LLC

Please complete the following information. Please print clearly.

Patient Information:

Patient Name: _____ Date of Birth: _____Age:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: _____ Ethnicity: _____Preferred Language: _____

SSN: _____ Employment Status:_____ Current Occupation:_____

Address: _____City/State: _____ Zip: _____

Home Phone: _____Cell Phone: _____Work Phone:_____

Email Address:_____

Emergency Contact: _____

Relation to Patient:_____ Phone: _____

Billing Information: Please list the responsible party for any and all bills for the patient listed above.

Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Responsible Party Name: _____Date of Birth: _____

Address (if different from above):_____

Phone: _____ Email address:_____

Insurance Information: Please complete if you are **NOT** the health insurance policy holder.

Policy Holder Name: _____Date of Birth: _____

Patient's Relationship: _____

Patient Questionnaire:

Primary Care Physician:_____ Date of last visit with primary care physician:_____

Referring physician or how you heard about us:_____

Preferred Pharmacy:_____Location:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible to notify the office of any and all updates to the information listed above.

X _____ _____

Signature of Patient, Guarantor, or Personal Representative Date