

LET'S GET ACQUAINTED

*Affiliated Podiatrists and their staff are very pleased to welcome you to our office
Please answer the following questions to help us become better acquainted.*

ACCOUNT # _____

DATE: _____

PATIENT INFORMATION

SSN: _____ AGE: _____ DATE OF BIRTH: _____ Sex: F M

FIRST: _____ MIDDLE: _____ LAST: _____

ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: () _____

EMPLOYER: _____ PHONE: () _____

MEDICAL DOCTOR: _____ PHONE: () _____
(Last) (First)

REFERRED BY: _____

MARTIAL STATUS: S M W D SEP SPOUSE'S NAME: _____

NEAREST RELATIVE NOT LIVING AT THE ADDRESS:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: () _____

GUARANTOR INFORMATION, IF DIFFERENT FROM ABOVE:

NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: () _____

EMPLOYER: _____ PHONE: () _____

INSURANCE INFORMATION:

Insurance Company Subscriber Name DOB Policy #

1. _____

2. _____

(over, please)