

PRECISION FOOT & ANKLE CENTER, PC

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (H) _____ (W) _____ (C) _____

Date of Birth: ___/___/___ Age: _____ Soc.Security #: _____ * Driver's License #: _____

Marital Status: S / M / D / W Sex: M / F *Race: _____ *Language: _____

Ethnicity: Hispanic / Non-Hispanic / Refuse (circle one please)

Employer: _____

Emergency Contact

Address: _____

Name: _____

Phone #: _____

Phone #: _____

Relationship to Patient: _____

Occupation: _____

Appointment Reminder: Choose one ___Leave a message ___Do not leave a message

Primary Care Physician: First Name: _____ Last : _____

Did he/she refer you here? _____ Date of Last Visit: _____

Pharmacy: Name: _____ Address: _____

IF INSURANCE IS NOT IN YOUR NAME, PLEASE FILL OUT THE FOLLOWING:

Insured's Last Name: _____ Insured's First Name: _____

Insured's Soc.Security #: _____ Insured's D.O.B.: ___/___/___

Insured's Address: _____ Occupation: _____

Employer's Name & Address: _____

Work Phone Number: _____

How did you hear about our office?:

* Our office is a paperless office and due to government guidelines for electronic medical records, we are required to ask the above questions.