

FAMILY PODIATRY CENTER, P. C.

PATIENT NAME _____ **DATE OF BIRTH** _____ **SEX** M F **AGE** _____

MAILING ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

PHYSICAL ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____
(IF DIFFERENT FROM MAILING ADDRESS)

HOME PHONE _____ **WORK PHONE** _____ **CELL PHONE** _____

MARITAL STATUS S M D W **SOCIAL SECURITY NUMBER** _____

EMPLOYER _____ **OCCUPATION** _____

EMPLOYER ADDRESS _____ **CITY, STATE, ZIP** _____

SPOUSE OR PARENT NAME _____ **SOCIAL SECURITY #** _____

SPOUSE OR PARENT EMPLOYER _____ **WORK NUMBER** _____

EMPLOYER ADDRESS _____ **CITY, STATE, ZIP** _____

NAME OF PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT _____

DO YOU HAVE? **INSURANCE** **MEDICARE** **MEDICAID**

DATE OF BIRTH OF INSURED _____

EMERGENCY CONTACT PERSON _____ **TELEPHONE #** _____

REFERRED BY _____

FAMILY PHYSICIAN _____ **TELEPHONE #** _____

PATIENT HEIGHT _____ **WEIGHT** _____ **SHOE SIZE** _____ **WIDTH** _____

WHAT BRINGS YOU TO THE OFFICE TODAY CONCERNING YOUR FOOT OR ANKLE? _____

NAME OF PHARMACY _____ **TELEPHONE #** _____

I HEREBY GIVE MY PERMISSION FOR DR. CUSHNER AND/OR DR. CUPOLO TO EXAMINE AND TREAT MY FEET. I WILL ASSUME FULL RESPONSIBILITY FOR PAYMENT OF SUCH TREATMENT.

SIGNATURE _____ **DATE** _____