

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. BECKER TO EXAMINE AND TREAT MY FEET. I WILL ASSUME FULL RESPONSIBILITY FOR PAYMENT OF SUCH TREATMENT.

SIGNATURE _____ DATE _____