Clark Podiatry Center
"We Keep You Walking."

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Patient Information

Today's date: _______________

____ Age: _____ Birth date: _________________
Last Name First name MI

Local Address: ____ Social Security #: _____________________

City: ______________________ State:____ Zip: _________ Home phone #: _______________ Cell phone #: _________________

E-mail address: ______________________________ Sex: M / F Marital Status: S M W D Domestic partner

Other address (if any): ____ Phone#: ______________________

Spouse's name: ____ Are they our patient? Yes / No

Are any of your friends, relatives or associates our patient? Yes / No If yes, who? ______________________________

If under 18, name of parent/guardian ______________________________ Relationship to patient: ______________________

Responsible party's name: ____________________________ Birth date: ____________ Social security #: ___________________

Whom may we thank for your referral? ______________________________ How did you hear about our practice? __________________

If you used the internet to find us, what search terms were used? ____

Work Information: Occupation:______________________________ If retired, former occupation: ______________________

Patient's Employer: ______________________________ Business phone: _______________

Employer address: ____

Insurance Information

Primary Insurance Company: ____________________________ Policy #: ______________________________

Name of policyholder: ______________________________ Birth date:___________________

Secondary Insurance Company: __________________________ Policy #: ______________________________

Name of policyholder: ______________________________ Birth date:___________________

Emergency contact information

Name: ______________________________________ Relationship: ___________________________

Home phone: ____________________ Business phone: ___________________ Cell phone: ___________________

Address: ____

May we discuss your condition and/or test results with them? Yes____ No____

Physician information

Primary care physician: ____ Last visit: ___________________

Former Podiatrist Name: ____ Last visit: ___________________

Other physician: ____ Last visit: ___________________

Other physician: ____ Last visit: ___________________

Pharmacy: ____