



# HARLIS FAMILY FOOT AND ANKLE

WHERE YOUR FOOT CARE IS A FAMILY MATTER

DATE: \_\_\_/\_\_\_/\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_ SEX: M F

HOME ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

WORK PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

CELL PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

E-MAIL: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

PRIMARY LANGUAGE: \_\_\_\_\_

RACE: \_\_\_\_\_

ETHNICITY: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Patient Name:**

**Date of Birth:**



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WHERE YOUR FOOT CARE IS A FAMILY MATTER

PRIMARY CARE DOCTOR: \_\_\_\_\_

PHONE: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE #:(\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION WITH? YES NO

IF YES,  
NAME(S) \_\_\_\_\_

WHO IS RESPONSIBLE FOR PAYMENT? \_\_\_\_\_

RELATIONSHIP TO PATIENT? \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #:(\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

WHO REFERRED YOU TO US?

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY NAME:

ADDRESS: \_\_\_\_\_ CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #:(\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_ INSURED NAME: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ EMPLOYER \_\_\_\_\_

CONTRACT # \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME:

**Patient Name:**

**Date of Birth:**

