

GRESHAM FOOT CLINIC PATIENT INFORMATION FORM

(PLEASE PRINT)

DATE: ____/____/____ PATIENT NAME: _____
LAST FIRST MI AGE _____

DATE OF BIRTH: ____/____/____ MALE FEMALE OTHER MARRIED SINGLE OTHER

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

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HOME PHONE: (_____) _____-_____ YES NO WORK PHONE: (_____) _____-_____ YES NO

CELL PHONE: (_____) _____-_____ YES NO E-MAIL: _____ YES NO

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE : (_____) _____ YES NO

ANY PERSON(S) YOU WOULD LIKE US TO SHARE YOUR MEDICAL INFORMATION WITH? ____ NO ____ YES

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE : (_____) _____

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

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE : (_____) _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE: (_____) _____-_____

PRIMARY CARE DOCTOR: _____ PHONE: (_____) _____-_____

PHARMACY: _____ LOCATION: _____ PHONE: (_____) _____-_____

EMPLOYER _____ OCCUPATION: _____

WHO REFERRED YOU TO US?

PRIMARY INSURANCE COVERAGE _____ DATE OF BIRTH OF PRIMARY INSURED ____/____/____ (needed for billing insurance)

SECOND INSURANCE COVERAGE _____ DATE OF BIRTH OF PRIMARY INSURED ____/____/____ (needed for billing insurance)

BY SIGNING BELOW I ACKNOWLEDGE THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE DR KENNEDY AND OR DR LANTSBERGER AND THEIR STAFF PERMISSION TO EXAMINE AND OFFER TREATMENT I APPROVE. I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES INCURRED BY MYSELF/PATIENT IF INSURANCE DOES NOT APPROVE OR PAY OR IF I HAVE NOT OBTAINED PRIOR AUTHORIZATION OR APPROPRIATE REFERRAL. I AGREE TO PAY \$50 IF I FAIL TO KEEP MY APPOINTMENT OR DO NOT CANCEL 24 HOURS PRIOR TO MY APPOINTMENT TIME.

PRINT NAME OF PATIENT

PRINT NAME OF GUARDIAN IF UNDER 18

SIGNATURE OF PATIENT OR GUARDIAN

DATE