Four States Foot Clinic

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Name: _____ Date of Birth:_____

SS#: _____ Sex: _____ Race/Ethnicity: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____
Home, Cell, Other (circle) Home, Cell, Other (circle)

PLEASE SPECIFY (BY CIRCLING) YOUR PREFERENCE FOR APPOINTMENT REMINDER: CALL OR TEXT

Married Single Divorced Separated Widowed

Email Address: _____ Enable Portal: Yes / No

Employer: _____Work Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy: _____ Location: _____

Responsible Party
(if other than the patient)

Name: _____ Sex: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ SS#_____
Home, Cell, Other (circle)

Relationship to the patient: _____

Employer: _____ Phone: _____

Guardian Name (print): _____

Patient / Guardian Signature:_____ Date:_____