Patient Fact Sheet

First Name_____ Last Name _____ M or F Todays Date_____

Birthdate_____ Age_____ Email _____ SSN_____

If patient is a minor, responsible adult _____ SSN_____

Home Address_____ City_____

State _____ Zip _____ Phone Number _____

Employer _____ Occupation_____

Address _____ City _____ Phone _____

Spouses Name _____ SSN _____ DOB _____

Nearest Relative not Living with you _____

Home Phone _____ Work Phone _____

Home Address _____

Your Physician _____ Phone # _____

Address _____

Pharmacy _____ Phone #_____

Whom may we thank for referring you to us? _____

Dear Patient,

Due to many insurance changes, it is no longer an easy task to interpret each individual policy. We urge you, as the patient, to check with your insurance company before any treatment or surgery. It is your responsibility to know if your insurance requires a referral, and to make sure your referral is active at the time of your appointment. It is also your responsibility to make sure your insurance will cover podiatry treatment. Failure to comply could result in you, as the patient, being responsible for all costs.

Sincerely,
GBFF

_____ _____

Patient signature Date