Podiatry Associates of IN, P.C.
Foot and Ankle Institute

2018

Mr. Mrs. Miss Ms Dr. (Circle)

Last Name | First | M.I. | Drivers License # | Date of Birth / Age

Street Address | Apt # | City / State | Zip Code

Is this a nursing home address? YES / NO (Circle)

Home Phone # | Cell Phone # | Allow Text Appt Confirmation YES / NO (Circle) | Work Phone # | Ext #

Language | Social Security # | Male / Female (Circle) | Email Address

Race: American Indian or Alaskan / Asian / Black / Caucasian / Declined / Other / Pacific Islander (Circle)

Ethnicity: Hispanic / Non-Hispanic / Declined (circle) married / single / widowed / divorced (Circle)

Spouse Name | Emergency Contact Name & Phone Number / Relationship to Patient

Patient's Employer | Street Address | City / State | Zip Code

Primary Care Physician's Name & Address | City / State | Zip Code | Phone Number

Referred By: Physician / Established Patient / Friend / Phone Book / Internet / Insurance (Circle) other/Name

(If Patient is a Minor) Responsible Parties Name & Address (Person in office w/ minor) | City / State | Zip Code

Responsible Parties Home # | Responsible Parties Work # | Responsible Parties Social Security # | Date of Birth

Responsible Parties Employer Name & Address | City / State | Zip Code

Primary Insurance Carrier | Policy Holder's Name | Member ID # / Group #

Policy Holder's Address (if different from patient's / responsible parties) | City / State | Zip Code

Policy Holder's Home Phone # | Policy Holder's Work Phone # | Policy Holder's Social Security # | Date of Birth

Policy Holder's Employer Name & Address | City / State | Zip Code

Secondary Insurance Carrier | Policy Holder's Name | Member ID # / Group #

Policy Holder's Address (if different from patient's / responsible parties) | City / State | Zip Code

Policy Holder's Home Phone # | Policy Holder's Work Phone # | Policy Holder's Social Security # | Date of Birth

Policy Holder's Employer Name & Address | City / State | Zip Code