Carolina Podiatry Group, Inc.
Patient Information
Personal History Date ____________

Legal Name ____
(Last) (First) (MI)

Name you would prefer to be called ____

Mailing Address ____

____
(City) (State) (Zip)

Phone No: ____________________________ **May we leave a message at this number? Y or N**

List all persons who we may speak with about your treatment ________________________________
____

Date of Birth: ___/___/___ **SSN:** __________________ **Sex: Male Female Shoe Size:** ________

Marital Status: Married _____ **Divorced** _____ **Single** ______ **Widowed:** ______

Occupation ______________________________ **Employer** __________________________________

Employer Address ____ **Phone No** _______________

Emergency Contact ____ **Phone No** _______________

Family Doctor _________________________________ **Date last seen by Family Doctor** ___/___/___

Family Doctor Address/Phone No ____

Did someone refer you to our office? If so, who? ____

Insurance Information

Do you have insurance? Y or N If not, be prepared to pay for visit in full <u>today</u>.

Insurance Co Name & Phone No ____

Policy Holder (employee) ______________________________ **Policy No**
____

Policy Holder Birthdate ____________________________ **Relationship to patient** _______________

<u>All Deductibles & Copays are due at time of service….TODAY</u>