## FOOT CARE CENTERS

## ***PATIENT INFORMATION SHEET***

**PATIENT NAME:** ________________________________________________________________

**ADDRESS:**___________________________ **City/State:**__________________ **Zip:**_____________

**HOME PHONE:**___________________ **Cell:**___________________ **Work:**____________________

**GENDER: F M DATE OF BIRTH:**_____ / ______ / ________ **SSN:**______ - ______ - ______

**HEIGHT:**________________________ **WEIGHT:**______________________

**RESPONSIBLE PARTY (IF OTHER THAN PATIENT):**___________________________________

**RESPONSIBLE PARTY SSN:**______________________ **DATE OF BIRTH:**_____ / ______ / _____

**PRIMARY INSURANCE COMPANY:**_____________________________________________

**Policy #**__________________________________ **Group #**__________________________________

**Employer Name**___________________________ **Address:**________________________________

**Subscriber Name**_________________________ **DOB**____________ **SSN:**____________________

**WHO REFERRED YOU TO US:**

**PRIMARY CARE PHYSICIAN:**_________________________ **DATE LAST SEEN:**____________

**ADDRESS:**_________________________________________ **PHONE:**______________________

**ETHNICITY:**

- **HISPANIC**
- **AFRICAN/AFRICAN AMERICAN**
- **ASIAN/ASIAN AMERICAN**
- **CAUCASION/EUROPEAN AMERICAN**
- **NATIVE AMERICAN/NATIVE ALASKAN**
- **NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER**
- **OTHER**

**PREFERRED LANGUAGE OTHER THAN ENGLISH:**__________________________________