Podiatry
ASSOCIATES OF TEXAS
Foot And Ankle Specialists

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Tel: (682) 262-1433
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PATIENT INTAKE FORM

NAME: (Last)…… (First)…… (MI)……

ADDRESS: …… Apt No……

CITY:…… STATE: …… ZIP:……

PATIENT PHONE #:…… Is this the number to call when making an appointment (Y) (N)

EMAIL: ……

DATE OF BIRTH: …… GENDER: (M) (F)

Marital Status: Single Married Widowed Divorced

Emergency Contact Name: …… Phone #:……

Relationship: ……

DOES PATIENT HAVE A (Power of Attorney)/Guardian YES NO (Skip this Section)

NAME …… RELATIONSHIP: ……

ADDRESS: …… Apt: ……

CITY:…… STATE …… ZIP: ……

POA/GUARDIAN PHONE #:…… Notify before each visit (YES) (NO)

INSURANCE CARRIER: ……

POLICY NUMBER: …… GROUP NUMBER: ……

TYPE OF POLICY: 1. HMO 2. PPO 3. POS 4. TRADITIONAL MEDICARE 5. MEDICARE ADVANTAGE

SECONDARY/SUPPLEMENT CARRIER: ……

POLICY NUMBER:…… GROUP NUMBER: ……

REASON FOR REFFERAL/VISIT:……

……

REFFERING PARTY:…… PHONE NUMBER:……

PRIMARY CARE PHYSICIAN …… PHONE NUMBER ……

HOW DID YOU HEAR ABOUT US:

1. INTERNET: A) Google…… B)Bing…… c)Other……

3. PROFESSIONAL REFFERAL: Doctor/Nurse/Clinic/ Insurance Company:……

4. OTHER (specify)……