InStride Family Foot Care

PATIENT INFORMATION SHEET

NAME:_____ **DATE OF BIRTH:**_____

SEX: M ☐ F ☐ MARITAL STATUS: S ☐ M ☐ D ☐ W ☐

ADDRESS:_____
street or box # city or town state zip

HOME PHONE:_____ **WORK PHONE:**_____

EMPLOYER:_____ SPOUSE'S NAME:_____

EMAIL:_____ May we email you periodically? ☐ Yes ☐ No

CONTACT IN CASE OF EMERGENCY: NAME_____

PHONE #_____ RELATIONSHIP TO PATIENT_____

HOW DID YOU FIND OUT ABOUT US?: FAMILY ☐ FRIEND ☐ NURSE ☐

DOCTOR ☐ PHONE BOOK ☐ SIGN ☐ OTHER:☐_____

PRIMARY INSURANCE:_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB: _____

SECONDARY INSURANCE:_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE:_____

FAMILY DOCTOR: _____ LAST VISIT:_____

_____ _____
SIGNATURE DATE