SUPPAN FOOT & ANKLE CLINIC

Please Print

Patient No.: _____ Date Completed: _____

Patient Information:

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Social Security No.: _____ Age: _____ Date of Birth: _____

Marital Status: (Circle One) Single/Married/Widow/Divorced

Phone: Home ( ) _____ Bus. ( ) _____ Cell ( ) _____

E-mail address: _____

How do you prefer we contact you? ☐ home ☐ cell ☐ business ☐ e-mail ☐ U.S. mail

EMERGENCY CONTACT: Name: _____ Phone No.: _____

Relationship: _____

Federal guidelines are requiring us to obtain the following information:

Preferred Language: _____

Do you consider yourself Hispanic/Latino?
- ☐ Yes
- ☐ No
- ☐ Decline to Specify

Gender: ☐ Male ☐ Female

Which category best describes your race?
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Decline to specify

Spouse:

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Social Security No.: _____ Date of Birth: _____

Parent Information: (mother or father if child)

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Social Security No.: _____ Date of Birth: _____

POA Information:

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Phone – Home: ( ) _____ Business : ( ) _____

Social Security No.: _____ Date of Birth: _____

Parent/Guardian: (mother or father if child)

First: _____ MI: _____ Last: _____

Address: _____ City/State: _____ Zip: _____

Employer: _____ City/State: _____

Phone – Home: ( ) _____ Business : ( ) _____

Social Security No.: _____ Date of Birth: _____

Were you referred to us? No/Yes If yes, by whom? _____

Family Doctor: _____ City/State: _____

Specialist: _____ City/State: _____