Office use
Account #_____

Doctor _____

Spokane Foot Clinic

PATIENT INFORMATION
Please print

Mr. Mrs. Ms.
Name_____
First Middle Initial Last Preferred name

□ **Female** □ **Male** **Social Security #** _____ **DOB** ___/___/___
M D Y

Address_____
Number Street City State Zip

Primary ( )_____ **Cell** ( ) _____**Work** ( ) _____

Email address_____

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino
Primary Language_____
Race (please circle) White Asian American Indian or Alaska Native Black or African American Other
Marital Status- (circle one) Divorced Married Partner Single Widowed Legally Separated
Student: (circle one) Full time Not a Student Part time **Employment:** _FT _PT _Not Employed
Employer_____
Referral Source (circle one) Friend/Family Insurance Provider Internet Our Website Phone book
Street sign TV or Other_____
Primary Physician _____**Date Last Seen** _____
Referring Physician_____
Emergency Contact_____ **Emergency Phone**_____

GUARANTOR (If different than self)
Name_____ DOB ___/___/___
First Middle Last M D Y
Address_____
Number Street City State Zip
Primary Phone ( ) _____**Guarantor social security #** _____

SUBSCRIBER INFORMATION (primary insurance holder – if different than self**)**
Relationship: (circle one) Self Spouse Child
Mr. Mrs. Ms. □ Female □ Male
Subcriber_____
First Middle Last
Address _____ **Primary phone**_____
Number Street City State Zip

Policy Holders Date Of Birth ___/___/___ **Business Phone** ( ) _____
M D Y
Employer_____ **Social Security#**_____

NOTICE OF PRIVACY PRACTICES
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the Notice.

DATE ___/___/___ **Print Name** _____**Signature** _____

Revised 11/2020