Office use
Account #_____
Doctor _____

Spokane Foot Clinic

PATIENT INFORMATION
Please print

Mr. Mrs. Ms.
Name_____
First Middle Initial Last Nickname
□ **Female** □ **Male** **Social Security #** _____ **DOB** ___/ ___/ ___
Email address_____ M D Y
Address_____
Number Street City State Zip
Primary Phone ( )_____ **Cell Phone** _____
Work Phone_____

Primary Physician_____**Date Last Seen**_____
Emergency Contact_____**Emergency Phone**_____
Primary Language_____
Race (please circle) White Asian American Indian or Alaska Native Black or African American Other
Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino
Referral Source (circle one) Friend/Family Insurance Provider Internet Our Website Phone book Street sign TV or Other_____
Referring Physician_____

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_____
Guarantor If different than Patient) Primary Phone_____
Mr. Mrs. Ms.
Name_____ DOB ___/___/___
First Middle Last M D Y
Address_____
Number Street City State Zip
Business Phone ( ) _____**Guarantor social security #** _____
SUBSCRIBER INFORMATION (card holder if different than patient)
Mr. Mrs. Ms. □ Female □ Male
Subcriber_____
First Middle Last
Address _____ **Primary phone**_____
Number Street City State Zip

Policy Holders Date Of Birth ___/___/___
M D Y
Employer_____**SocialSecurity#**_____

Business Phone ( )_____

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** _____