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: ____

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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

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Spouse: **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: **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: _____________________________

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

Family Doctor: ____ City/State: ______________________

Specialist: ____ City/State: ______________________