



Gadsden Foot Clinic, PC

306 South 4th Street
Gadsden, AL 35901

PATIENT INFORMATION

Last Name _____ First Name _____ Birth Date _____ Ht _____ Wt _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Marital Status: S M D W SS# _____

Employed by _____ Occupation _____ Email Address _____

Employer's Address _____ Business Phone _____

IN CASE OF EMERGENCY NOTIFY _____ Phone _____ Relation _____

Name of (Husband) (Wife) (Parent) _____

Employed by _____ Occupation _____

Employer's Address _____ Business Phone _____

Relative or Friend Not Living with Patient _____ Phone _____

PERSON RESPONSIBLE FOR ACCOUNT _____

We do not bill absent parents. The adult presenting with the minor for care is the Responsible Party.

Name	Address	SS#	DL#
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Medical Insurance

Primary Insurance Co Name _____ Patient is Subscriber Dependent
 Policy # _____ Subscribers Date of Birth _____

Secondary Insurance _____ Patient is Subscriber Dependent
 Policy # _____ Subscribers Date of Birth _____

Family Doctor _____ Last Visit _____

Previous Podiatrist _____ Last Visit _____

Whom may we thank for referring you to our office? _____ Pharmacy _____

Name _____

What is your chief foot complaint? _____

How long have you had it? _____

Has your foot problem been getting worse? _____

What have you done for your foot problem? _____

Have you ever worn arch supports? _____

Date _____ Patient Signature _____

Date _____ Signature of Responsible Party _____