



Gadsden Foot Clinic, PC

306 South 4th Street
Gadsden, AL 35901

PATIENT INFORMATION

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

Address _____ City _____ Zip _____

Telephone _____ 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 _____

Medical Insurance

Private Insurance Co Name _____

Group Policy # _____

Medicare Second Insurance _____

Policy # _____

Family Doctor _____ Last Visit _____

Previous Podiatrist _____ Last Visit _____

Whom may be thank for referring you to our office?

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 _____