CENTRAL WASHINGTON PODIATRY SERVICE

PATIENT INFORMATION

Last Name: ________________________________ First Name: __________________________ SSN#: _________________

Address: ____ City: ___________________________ Zip Code:_______________

Home Phone: _______________________________ Cell Phone: ________________________ DOB:__________ Age: ____

Sex: (M) (F) Status: (S) (M) (W) (D) Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino

❒ American Indian/ Alaskan Native ❒ Native Hawaiian/ Other Pacific Islander ❒ Asian

❒ Black/ African American ❒White Language: ❒ English ❒ Spanish

Employer: _______________________________ Work Phone: ________________________ Extension: ________________

Spouse's Name: ______________________________ SS#: ________________________ D.O.B.:_______________________

Spouse's Employer: ___________________________________ Phone: ____

Responsible Party for Bill: ❒ Patient ❒ Spouse ❒ Father ❒ Mother

If Child (Dependent):

Father's Name: _________________________________ SS#: _______________________ **D.O.B.:**________________

Father's Address: ____ Phone: _________________________________

Father's Employer: ____

Mother's Name: _________________________________ SS#: _______________________ **D.O.B.:**______________

Mother's Address: ____ Phone: ________________________________

Mother's Employer: ____

Primary Doctor: ____________________________ Referring Doctor: _____________________ Pharmacy: _______________

Primary Insurance: ____

Subscriber: ______________________________________ ID#____________________________ Group #_________________

Secondary Insurance: ____

Subscriber: ______________________________________ ID#____________________________ Group #_________________

Name of friend or relative who is not currently residing at your residence, and phone # for emergency:

____

Whom may we thank for suggesting that you come to our office? Name and address below:

____

I authorize release of medication information necessary to process claim. I authorize payment of medical benefits to Central Washington Podiatry Service, PLLC: ____

Patient Signature/Guardian Signature