

OREGON FOOT CLINIC

Patient Name _____ Age _____ Sex _____ Birthdate _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____

Marital Status: Married/Partnered Single Widowed Divorced Separated

Social Security # _____

Occupation _____

Name of Employer _____

Employment Address _____ City _____ State _____ Zip _____

Referred by _____

Is this your primary care physician? Y N If not, PCP's Name _____

Name of Spouse (Parent if Minor) _____ Birthdate _____

Spouse/Parent Employer _____ Work phone () _____

Employment Address _____ City _____ State _____ Zip _____

Occupation _____ Social Security # _____

In case of emergency, notify _____ Phone # () _____

Relationship _____

Foot-related problem you are here for today: Right/Left _____

Doctors who have seen your for this condition _____

INSURANCE INFORMATION:

Primary Insurance _____

Insured's Name _____ Relationship to Patient _____

Address (if different from patient) _____

Referral Required? Y N

Secondary Insurance _____

Insured's Name _____

Referral Required? Y N

[] No insurance

**This office does not handle
Worker's Compensation, Motor Vehicle Accidents or Third-party Liabilities**