WELCOME TO CEDAR VALLEY PODIATRY FOOT & ANKLE CENTER

PATIENT INFORMATION

FIRST NAME MIDDLE INITIAL LAST	NAME YOU LIKE TO USE	DATE OF BIRTH	AGE
GENDER: ❑ FEMALE ❑ MALE MARITAL STATUS: S M W D	SOCIAL SECURITY		

STREET ADDRESS	CITY	STATE	ZIP CODE	E MAIL

HOME PHONE	CELL PHONE	EMPLOYER	WORK PHONE

PREFERRED METHOD OF CONTACT	PREVIOUS NAME
ETHNICITY: ❑ HISPANIC OR LATINO ❑ NON-HISPANIC OR LATINO	
PREFERRED LANGUAGE	HEIGHT: WEIGHT: SHOE SIZE:

RACE: ❑ AMERICAN OR ALASKA NATIVE ❑ ASIAN ❑ BLACK OR AFRICAN AMERICAN
❑ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ❑ WHITE

NAME OF SPOUSE/PARENT/GUARDIAN & ADDRESS IF DIFFERENT FROM PATIENT

SPOUSE/PARENT/GUARDIAN PHONE NUMBER

EMERGENCY CONTACT NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

FAMILY DOCTOR NAME AND ADDRESS

REFERRED BY (IF DR INCLUDE ADDRESS)

INSURANCE INFORMATION

PLEASE HAVE INSURANCE CARD READY FOR RECEPTIONIST TO COPY

PRIMARY INSURANCE COMPANY NAME AND ADDRESS		POLICY HOLDER NAME		RELATIONSHIP
		POLICY HOLDER ADDRESS		
POLICY ID NUMBER	GROUP NUMBER	DATE OF BIRTH	SOCIAL SECURITY	HOME PHONE
SECONDARY INSURANCE COMPANY NAME AND ADDRESS		POLICY HOLDER NAME		
		POLICY HOLDER ADDRESS		
POLICY ID NUMBER	GROUP NUMBER	DATE OF BIRTH	SOCIAL SECURITY	HOME PHONE
IS TODAY'S VISIT DUE TO INJURY? Y/N INJURY DATE		Did this injury occur at work? If yes complete back of form.		

I request that payment of benefits be made on my behalf to Cedar Valley Podiatry for services rendered. I authorize any holder of medical or other information about me to release any information needed to determine these benefits or benefits for related services.

Signature: ______________________ Today's Date: ______________________

Signature Update: ______________________ Today's Date: ______________________