

Joel D. Foster DPM, PC

Welcome to Our Office

This sheet provides us with information vital to your health and will aid our office in accurately filling your insurance forms. Be assured that this information will remain strictly confidential. Please take a moment to complete this form.

PATIENT INFORMATION

TODAY'S DATE _____

Patient's full name _____

MARITAL STATUS (circle) Single Married Widowed Divorced Gender: (circle) Male Female

Social Security No. _____ Birth Date _____ Age _____

Street Address _____ Home Phone _____

City, State, Zip _____ Email _____

Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Employer Address _____

RESPONSIBLE PARTY OR NAME INSURANCE UNDER

Name _____

Social Security No. _____ Birth Date _____ Home Phone _____

Street Address _____ City, State, Zip _____

Employer _____ Employer Address _____

MEDICAL INFORMATION

Family Doctor _____ Last visit to family doctor _____

In case of emergency, please call (Name/Relationship) _____ Phone _____

MEDICAL INSURANCE

HMO _____ PPO _____ CO-PAY \$ _____

Primary Company _____ Secondary Company _____

Subscriber _____ Subscriber _____

Certificate# _____ Certificate# _____

Group# _____ Group# _____

REFERRAL INFORMATION

Please take a moment to tell us how you found out about our practice. Please check as many as necessary.

My family doctor, Dr. _____ Patient from this practice _____

Another doctor, Dr. _____ Yellow page (which one?) _____

Friend, co-worker _____ Web site or web search _____

Radio/TV(which station?) _____ Insurance web site or directory _____

Other _____