Foot Care of Central San Antonio
Patient Information Sheet
(Please Print)

Date: _____

Patient's Last Name: _____ **First:** _____ **MI:** _____

[Mr.] [Miss] [Mrs.] [Ms.] D.O.B.: _____ **SS#:** _____

Sex: M or F **Marital Status:** (Single) (Married) (Widowed) (Divorced) (Separated)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

HM#: _____ **WRK#:** _____ **CELL#:** _____ **Email:** _____

Primary Physician: _____ **Ph#:** _____ **Fax#:** _____

Referred By: _____ **Employer:** _____ **Employer#:** _____

PERSON RESPONSIBLE FOR BILL
(If Other Than Above)

Name: _____ **Relationship:** _____ **Ph#:** _____

INSURANCE/RX CARD INFORMATION – PHOTO COPY NEEDED

EMERGENCY CONTACT

Name: _____ **Ph#:** _____ **Relationship:** _____

AUTHORIZATIONS

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance(s). I authorize Foot Care of Central San Antonio or the insurance company to release any information required to process claims.

Signature: _____ **Date:** _____

Account#: _____