PATIENT INFORMATION

Dr Joel Bowen DPM

Patient's Name _____ Patient's Social Security _____

Patient's Address (local) _____ Birthdate ____/____/_____ Age _____

City _____ State _____ Zip _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep ☐ Other

Phone # (local) _____ Spouse Name _____

Cell Ph # _____ Permanent Address _____

Responsible Party (if minor) _____ City _____ State _____ Zip _____

Responsible Party Address _____ Responsible Party Phone # _____

City _____ State _____ Zip _____ Email _____

Meaningful Use:

Race (Select One): ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic or Latino ☐ Pacific Islander ☐ White ☐ Other (indicate)

Primary Language: _____ _____

EMPLOYMENT INFORMATION Patient/Parent Occupation _____

Patient/Parent Employer _____ Spouse's Employer _____

Employer Address _____ Employer Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Employer Phone # _____ Employer Phone # _____

INSURANCE INFORMATION – We will copy your insurance card but we need you to fill out this section!

Primary Insurance _____ Secondary Insurance _____

Ins Co Address _____ Ins Co Address _____

City _____ State _____ Zip _____ City _____ State _____Zip _____

Ins Co Phone # _____ Ins Co Phone # _____

Cardholder Name _____ Cardholder Name _____

Relationship to Patient _____ Relationship to Patient _____

Group #_____ ID # _____ Group # _____ ID # or SS# _____

Insured Date of Birth _____ Sex ☐ M ☐ F Insured Date of Birth _____ Sex ☐ M ☐ F

ACCIDENT INFORMATION

Date of Accident _____ How/Where _____

Work Related: ☐ Y ☐ N Were you treated by another Doctor for this injury? ☐ Y ☐ N

Doctor's Name _____ Phone # _____

Family Doctor _____ Phone # _____

Former Podiatrist _____ Phone # _____

Referred by _____

By signing this document:

1. I hereby give my permission to administer treatment, and to perform such procedures as may be necessary in diagnosis and treatment.
2. I will furnish insurance forms & information and I agree to pay my co-payment, deductible and non-covered portions at the time of my visit or when billed by the office.
3. *Minors* I agree that I am the legal guardian of this patient, and understand that **only** the legal guardian is allowed in the exam room.
4. I understand that a photograph may be taken of me for insurance verification purposes, and if I disagree with this process I will let the office know.

Patient Signature: _____ Date: _____