New Patient Information Sheet

FOOT & ANKLE
SPECIALISTS OF IDAHO

Personal Information

Patient Name_____
Last Name First Name Middle Initial

Date of Birth _____ Sex: F M

Social Security Number_____

Contact Information

Mobile Phone_____ Email: _____

Send Mobile Text Notifications? Y/ N
Send Voice Notifications? Y / N
Send Email Notifications? Y / N

Home Phone _____ Work / Other Phone _____

Home Address_____
City State Zip

Preferred method of Communication: (Circle all that apply)
Email Mobile Phone
Home Phone Work Phone Mail

How did you hear about us? _____

Primary Insurance _____

Plan Name_____

Insurance ID_____ Group ID_____

Effective From_____ Copay Type_____

Employer Name _____

Patient Relationship to Guarantor: Self Child Spouse Other_____

(skip if self) Guarantor Name _____
Last Name First Name

Guarantor Address _____

Date of Birth _____ Sex: M F SSN#_____

Primary Phone Number _____ Secondary Phone_____

Secondary Insurance (skip if no secondary insurance)_____

Plan Name_____

Insurance ID_____ Group ID_____

Effective From_____ Copay Type_____

Patient Relationship to Guarantor: Self Child Spouse Other_____

(Skip if self) Guarantor Name _____
Last Name First Name

Guarantor Address _____
City State Zip

Date of Birth _____ Sex: M F SSN#_____

Primary Phone Number _____ Secondary Phone_____

Race

[] American Indian or Alaska Native
[] Asian
[] White/ Caucasian
[] Decline to Specify/ Other
[] Native Hawaiian or Other Pacific Islander
[] Black or African American
[] Hispanic / Latino

Next of Kin/ emergency contact_____

Relation to Patient_____ Phone_____

Address _____

Mothers Maiden Name _____