Edmond Podiatry, LLC dba **Central Oklahoma Foot and Ankle Center**

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other: _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth _____/_____/_____

Phone Numbers: Home _____ Work _____

Cellular _____ *May we leave a message on your phone? ☐Yes ☐No*

E-Mail _____

Address _____

City, State, ZIP _____

Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Self Employed ☐ Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Contact Number _____ Relationship _____

Primary Care Physician _____ Referring Provider _____

RESPONSIBLE PARTY INFORMATION

☐ **SELF** *or* Name: (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth _____/_____/_____

Phone Numbers: Home _____ Cellular _____ Work _____

Address _____

City, State, ZIP _____

Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Self Employed ☐ Unemployed

Employer _____ Occupation _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Policyholder: _____ Patient Relationship to Policyholder _____

Policyholder Employer Name _____

Insurance Company/Phone Number _____ ( )

Member ID _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Policyholder Date of Birth _____/_____/_____ Policyholder Social Security Number _____-_____-_____

Insurance Company Address _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Policyholder: _____ Patient Relationship to Policyholder _____

Policyholder Employer Name _____

Insurance Company/Phone Number _____ ( )

Member ID _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Policyholder Date of Birth _____/_____/_____ Policyholder Social Security Number _____-_____-_____

Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____