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Phone: 256-840-4810 • Fax 256-840-4815

New Patient Information

Last Name: _____First Name: _____ Middle Initial_____ Sex: M / F

Social Security Number_____ Date of Birth: _____ Marital Status: _____

Street Address: _____

City/State/Zip: _____

Email Address: _____

Home Phone: _____Cell: _____ Work Phone _____ ext. _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Primary Care Physician: _____ Date of Last Visit: _____ Pharmacy: _____

Employer: _____ Employer Phone Number: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

With whom may we discuss your person medical information?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

May we leave a message at your home with a family member or friend? Yes / No

May we leave a message on voicemail or an answering machine? Yes / No

May we call you at your place of employment? Yes / No

Are you the primary carrier of your insurance? Yes/No

If not who is the primary Holder _____ Date of Birth: _____ Relationship: _____

How did you hear about us? Internet _____ Facebook _____ Friend _____ Other _____

** If a friend referred you, please write their names so we can thank them: _____

Are you under a pain management contract? Y / N

If so, by whom: _____

Do have an advanced directive? Y /N

Allegiance Family Foot Care adheres to all regulations and requirements set forth by HIPPA Privacy Act. This includes all information regarding your personal health information. A copy of our complete privacy policy is available upon request.

Name (print): _____ Signature_____ Date _____

Patient/Guardian Patient/Guardian