PODIATRY ASSOCIATES OF WAUSAU, S.C.

DATE _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street: _____ Apt # _____ Home Phone# (_____) _____ - _____

PO Box (if any) _____ Alternative Phone # (_____) _____ - _____

City / State _____ Zip _____ Social Security # _____

Sex: M F Birth Date: _____ Age: _____ ☐ Single ☐ Married ☐ Other _____

What name you prefer to be called: _____ Name of spouse/parent _____

Employed? ☐ None ☐ Full Time ☐ Part Time ☐ Retired Student? ☐ Full Time ☐ Part Time

Employer: _____ Work Phone: (_____) _____ - _____ Ext: _____

General Physician's Name _____ Date of last visit _____
First Name Last Name

Name of Clinic: _____ City/State: _____

How did you hear about our office: ☐ Newspaper ☐ Phone Book ☐ Physician _____
Referring Physician Name Please

☐ TV ☐ Web Site ☐ Insurance ☐ Friend ☐ Family ☐ Location ☐ Other _____

RESPONSIBLE PARTY

Who is responsible for patient bill ☐ Spouse ☐ Parent ☐ Guardian / POA ☐ Other _____
(fill in only if other than patient).

Last Name: _____ First Name: _____ MI: _____

Street: _____ City/State: _____ Zip: _____

Home Phone # _____ Alternative Phone # (_____) _____ - _____

Employer: _____ Work Phone # (_____) _____ - _____ Ext: _____

PRIMARY INSURANCE

Primary Insurance Company: _____

Policy No: _____ Group No: _____

Subscriber (if other than patient): ☐ Spouse ☐ Parent ☐ Stepparent ☐ Other _____

Last Name: _____ First Name: _____ MI: _____

Street: _____ City/State: _____ Zip: _____

Home Phone # (_____) _____ - _____ Alternative Phone # (_____) _____ - _____

Employer: _____ Work Phone # (_____) _____ - _____ Ext. _____

Birth Date: _____ Sex: M F

SECONDARY INSUREANCE

Secondary Insurance Company: _____

Policy No: _____ Group No: _____

Subscriber (if other than patient): ☐ Spouse ☐ Parent ☐ Stepparent ☐ Other _____

Last Name: _____ First Name: _____ MI: _____

Street: _____ City/State: _____ Zip: _____

Home Phone # (_____) _____ - _____ Alternative Phone # (_____) _____ - _____

Employer: _____ Work Phone # (_____) _____ - _____ Ext. _____

Birth Date: _____ Sex: M F

WORKERS COMP.

Workers Compensation Claims

Employer: _____ Claim ID # _____

Insurance Carrier: _____ Date of Accident: _____

Contact Person: _____ Phone #: _____

Address to Send Claim: _____ Date Symptoms Occurred: _____

_____

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