NORTH IDAHO
FOOT & ANKLE INSTITUTE

PATIENT INFORMATION

Today's Date: _____ ( ) Male ( ) Female

Patient First Name: _____ MI: _____ Last: _____ Age: _____

Date of Birth: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Primary Care Doctor: _____ Date Last Seen (mm/dd/yy): _____

Employer: _____ Occupation: _____

How did you hear about us? _____

Please Circle: Married Divorced Single Partner Widowed

What is the best way to contact you? Phone Mail Email Text Message

Ok to leave messages with: patient only spouse/guardian anyone answering the phone

Emergency Contact

Name: _____ Relationship to patient: _____ Phone #: _____

PERSON REQUESTING TREATMENT FOR MINOR CHILD IS CONSIDERED RESPONSIBLE FOR BILL.

Parent or Responsible Party: _____ DOB: _____ SS#: _____

Address if different from child: _____ Phone #: _____

If insurance is through another person please complete this portion

Name: _____ Relationship: _____ DOB: _____ Ph#: _____

Address if different: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

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