WESTERN OHIO PODIATRIC MEDICAL CENTER, INC.

415 W. Russ Road, Greenville, Ohio 45331

PATIENT INFORMATION: *PLEASE PRINT* **Patient #** _____
(office use only)

Name _____
Last Name First Name MI

Street Address_____ **P.O. Box**_____

City_____State_____Zip_____ Home (_____)_____

Cell (_____)_____

Birthdate _____ Sex: ☐ M ☐ F SS# _____

Is this a work related Injury: _____ Date of Injury: _____Claim #:_____

Employer _____ Business Phone (_____)_____

Emergency contact: _____ Relationship_____ Phone_____

Student: ☐ Full-time ☐ Part-time ☐ Not a student **Marital Status**: ☐ Single ☐ Married ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Island ☐ White ☐ Other_____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Primary Language**: _____

RESPONSIBLE PARTY / INSURANCE INFORMATION

Please provide the office staff with your insurance cards so we may photocopy them for pertinent insurance information.
*(**PLEASE COMPLETE THIS SECTION IF SUBSCRIBER IS OTHER THAN PATIENT**)*

Primary Insurance Name_____ Secondary Insurance Name _____

Subscriber's Name_____ Subscriber's Name_____

Subscriber's **Birthdate**_____ Subscriber's **Birthdate** _____

Subscriber's S.S. #_____ Subscriber's S.S. #_____

Relationship to Patient _____ Relationship to Patient _____

Subscriber's Address _____ Subscriber's Address _____

City _____ State _____ Zip _____City _____ State _____ Zip _____

MEDICAL INFORMATION

What foot/ankle problems are you having?_____

Any **changes** to your medical history?_____

Please list all **medications** you take on a regular basis. ***(If you have a list of your medications, our office staff will photocopy it.)***

_____

Are you **allergic**/sensitive to any medications? ☐ Yes ☐ No If yes, what medication(s):

_____

Family doctor: _____ **Pharmacy:** _____

Signature _____ **Date** _____