

***New York Foot Group L.L.P.***

Date \_\_\_\_\_

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Would you like appointment reminder through email?  Yes  No

Sex: M F Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Single  Married  Other \_\_\_\_\_

Social Security # \_\_\_\_\_

Are you employed?  None  Full Time  Part Time  Retired Student?  Yes  No

Employer: \_\_\_\_\_ Work# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext \_\_\_\_\_

General Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

How did you hear about our office:  Yellow pages  Website  Insurance  Friend  Family  
 Other \_\_\_\_\_

**Primary Insurance**

Insurance Company: \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Subscriber (if other than patient):  Spouse  Parent  Stepparent  Other \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_

Social Security # (Subscriber): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date (Subscriber) \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Subscriber (if other than patient):  Spouse  Parent  Stepparent  Other \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_

Social Security # (Subscriber): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date (Subscriber) \_\_\_\_\_