INDY PODIATRY
we love your feet
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9240 N. Meridian St. Suite 260
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Fishers, IN 46038

Date: _____

PATIENT INFORMATION

Patient Name: First: _____ Middle: _____ Last: _____

Name you Prefer: _____ **Date of Birth:** _____ **Gender:** _____

Patient SSN: _____ **Marital Status**: Married ☐ Single ☐ Other ☐

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone:** _____

Email: _____ **Preferred Method of Contact:** Phone ☐ Text ☐ Email ☐

Race: Asian ☐ Black or African American ☐ Caucasian ☐ Other ☐

Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐ **Veteran:** Yes ☐ No ☐

Primary Care Physician: _____

Referral Source: Doctor/PCP ☐ _____ Online ☐ Word of Mouth ☐ Social Media ☐

Event/Expo ☐ Family/Friend/Patient ☐ Insurance Company ☐

Pharmacy: _____ **Address:** _____ **Phone:** _____

PERSON RESPONSIBLE FOR BILL

Self ☐ (Please leave section blank if marked "Self") **Spouse** ☐ **Child** ☐ **Parent** ☐ **Other** ☐

Name: First: _____ Middle: _____ Last: _____

Date of Birth: _____ **SSN:** _____ **Gender:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone:** _____

INSURANCE

Primary Insurance: _____ **Policy Holder's Name:** _____

Policy Holder's DOB: _____ Patient Relationship to Holder: Self ☐ Spouse ☐ Child ☐

Secondary Insurance: _____ **Policy Holder's Name:** _____

Policy Holder's DOB: _____ Patient Relationship to Holder: Self ☐ Spouse ☐ Child ☐

EMERGENCY CONTACT

Name: _____ **Phone Number:** _____

Relationship to Patient: _____

Release Medical Records ☐ **Primary Contact** ☐ **Legal Guardian** ☐ **Resides With** ☐ **Primary Caregiver** ☐