OLIVER FOOT CLINIC, INC

PATIENT INFORMATION

Patient's Name _____
Last First Midddle Initial

Address _____ _____ _____ _____
Street City State Zip

Date of Birth ____/____/____ Age ____ Social Security # _____

Gender: (M / F) Marital Status: (Single / Married / Divorced / Widowed)

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Contact Preference: Email Phone Postal Txt

Ethnicity
- ❑ Unspecified
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Unknown

Race
- ❑ Unspecified
- ❑ White
- ❑ American Indian or Alaska Native
- ❑ Native Hawaiian or other Pacific Islander
- ❑ Black or African American
- ❑ Asian
- ❑ Other Race

Preferred Language
- ❑ English
- ❑ Spanish
- ❑ Other _____
- ❑ Unspecified

Employer _____ Occupation _____

Address _____ _____ _____ _____
Street City State Zip

Who to contact in an emergency:

Name _____ Relation _____ Phone # _____

If the patient is a minor, please complete this section:

Parent/Guarantor Name _____

Address _____ _____ _____ _____
Street City State Zip

Date of Birth ____/____/____ Age ____ Social Security # _____

Home Phone _____ Cell Phone _____ Work Phone _____

How did your hear of our clinic? *Physician / yellow pages / website / radio / insurance / friend*

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Primary Insurance Company _____

Subscriber Name _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Policy # _____ Group # _____ Employer _____

Patient's relationship to the policyholder: Self / Spouse / Dependent

Secondary Insurance Company _____

Subscriber Name _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____

Policy # _____ Group # _____ Employer _____

Patient's relationship to the policyholder: Self / Spouse / Dependent

All Patients, Please Read & Sign:

I authorize payment of medical benefits from Medicare, Tenncare, private and/or group insurance be made on my behalf to Oliver Foot Clinic for any services or supplies furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing administration or my insurance company any information needed to determine benefits for related services. I also take responsibility for payment of charges, regardless of payment or denial of payment from my insurance company.

_____ _____
Signature of Patient/Guarantor Date