FOOT & ANKLE SPECIALISTS
PATIENT DEMOGRAPHIC SHEET

☐ Michael R Powers, DPM ☐ Chad A Summy, DPM ☐ Shannon M Lensing DPM
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Patient's First Name:		**Middle Initial:**		**Patient's Last Name:**	
Patient's Social Security#		**Patient's Date of Birth**		**Gender**	☐ Male ☐ Female
Home Address					
City		**State**		**Zip+4**	
Mailing Address:	(if different from Home Address)				
City		**State**		**Zip+4**	
Phone: Home		**Preferred Phone Contact:** ☐ Home ☐ Cellular ☐ Work			
Phone: Cellular		**Preferred Communication Contact (For appointment reminders, lab results, etc.)** Phone: (☐ Home ☐ Cellular ☐ Work) ☐ Email ☐ Mail			
Phone: Work					
Email Address					
Emergency Contact Person	**Name**				
	Phone#		**Relationship**		

Please Check Related Box

Racial Category				Ethnicity		Preferred Language	
☐	African American	☐	American Indian/Alaska Native	☐ Hispanic/Latino		☐	English
☐	Asian	☐	Hispanic	☐ Not Hispanic/Latino		☐	Spanish
☐	Native Hawaiian	☐	More Than One Race	☐ Choose Not To Tell		☐	Choose Not To Tell
☐	White/Not Hispanic	☐	Choose NotToTell	☐		☐	Other:

Marital Status:	☐ Single ☐ Married ☐ Other
Job Description	
Employer/Address:	
Primary Physician Name:	
Primary Physician Address:	

Preferred Pharmacy	
Preferred Pharmacy Address	
How did you hear about us?	**Referral From:** ☐ Physician ☐ Friend ☐ Relative ☐ Current or Past Patient
	☐ Internet ☐ Phone Book ☐Newspaper ☐TV
	☐ Other/Source:

Insurance Policy Holder Information (if different from Patient)		**For The:** ☐ Primary ☐ Secondary
First Name		
Last Name		
Policy Holders' Address (if different from Patient's)		
Policy Holders' Social Security#		**Date of Birth:**
Patient's Relationship to Policy Holder:	☐ Self ☐ Spouse ☐ Child ☐ Other	

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

Patient and/or Guardian Signature: _____ Date: _____