West Georgia
Podiatry Associates, P.C.

# PATIENT INFORMATION

Gary S. Fields, DPM, FACFAS
Kenneth M. Danis, DPM, FACFAS

## DEMOGRAPHICS

| First Name | Middle Initial | Last Name | Gender ☐ M ☐ F |
|---|---|---|---|
| | | | |

| SSN | Birthdate | Age | Email |
|---|---|---|---|
| | | | |

| Mailing address: | Apt # |
|---|---|
| | |

| City: | State: | ZIP Code: | Home Phone | Cell Phone |
|---|---|---|---|---|
| | | | | |

## OTHER

| Primary Physician | Date Last Seen | Primary Language |
|---|---|---|
| | | |

**Race**: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African America ☐ Native Hawaiian/Pacific Islander ☐ White

**Ethnicity**: (check one) ☐ Not Specified ☐ Hispanic/Latino ☐ Not Hispanic/Latino

| Emergency Contact | Phone Number | Referral Source (How did you hear about us?) |
|---|---|---|
| | | |

## BILLING

Marital Status ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Widowed

Student Status ☐ Full Time Student ☐ Not a Student ☐ Part Time Student

Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed

| Employer Name | Phone Number |
|---|---|
| | |

## PREFERENCES

Contact Preferences

☐ Phone: ☐ Okay to leave a message with: ☐ Anyone ☐ Patient Only ☐ Patient or Spouse

☐ Mail ☐ E-Mail

## INSURANCE INFORMATION

| Primary Insurance Name | Policy Number | Group Number |
|---|---|---|
| | | |

| Subscriber Name (If not patient) | Birthddate |
|---|---|
| | |

| Secondary Insurance Name | Policy Number | Group Number |
|---|---|---|
| | | |

| Subscriber Name (If not patient) | Birthddate |
|---|---|
| | |