# Mid-Michigan Podiatry, PC
## PATIENT DEMOGRAPHIC INFORMATION

Date: _____

**PATIENT NAME:**_____
(LAST) (FIRST) (MIDDLE)

**SOCIAL SECURITY #:**_____ **DATE OF BIRTH:**_____

**GENDER:** MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED DIVORCED WIDOWED

**ADDRESS:**_____

**CITY:**_____ **STATE:**_____ **ZIP:**_____

**HOME PHONE:**_____ **WORK PHONE:**_____ **CELL PHONE:**_____

**OCCUPATION:**_____ **EMPLOYER:**_____

**E-MAIL ADDRESS:**_____
_____ **Please initial to allow our office to send appointment reminders to the above email address**

***WHO REFERRED YOU TO OUR OFFICE?***_____

**PRIMARY CARE PHYSICIAN:**_____

**PERSON TO CONTACT IN CASE OF EMERGENCY:**_____

**RELATIONSHIP TO PATIENT:**_____ **PHONE #:**_____

**IS INJURY/ILLNESS RELATED TO:** **AUTO ACCIDENT** **WORK** **OTHER(ACCIDENT)?** YES NO
**DATE OF ACCIDENT:**_____

***INSURANCE AND FINANCIAL RESPONSIBILITY INFORMATION:***

**WHO IS FINANCIALLY RESPONSIBLE FOR THE ACCOUNT?**

**NAME:**_____
(LAST) (FIRST) (MIDDLE)

**SOCIAL SECURITY #:**_____ **DATE OF BIRTH:**_____

**ADDRESS:**_____

**CITY:**_____ **STATE:**_____ **ZIP:**_____

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**WHO IS THE SUBSCRIBER OF THE PRIMARY INSURANCE? SELF SPOUSE DEPENDENT OTHER**

**NAME:**_____
(LAST) (FIRST) (MIDDLE)

**SOCIAL SECURITY #:**_____ **DATE OF BIRTH:**_____

**EMPLOYER**_____

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**WHO IS THE SUBSCRIBER OF THE SECONDARY INSURANCE? SELF SPOUSE DEPENDENT OTHER**

**NAME:**_____
(LAST) (FIRST) (MIDDLE)

**SOCIAL SECURITY #:**_____ **DATE OF BIRTH:**_____

**EMPLOYER**_____