Mid Plains Podiatry, PC
11071 W Maple Road
Omaha, NE 68164

Patient Information Form
(Please Print)

Date: ___/___/___

Patient Name: _____ _____ ___ Date of Birth: ___/___/___ Age: ___ Sex: M F
Last First MI

Social Security Number: _____ Height: _____ Weight: _____ Shoe Size: _____
Home Address: _____ City/State: _____ Zip: _____

Home Phone #: (___) ___-_____ Yes No
Work Phone #: (___) ___-_____ Yes No

Cell Phone #: (___) ___-_____ Yes No

Primary Language: _____

Do you have a legal guardian or healthcare power of attorney? Yes No
If yes, Name: _____ Relationship: _____ Phone #: (___) ___-_____

Emergency Contact: _____ Relationship: _____ Phone #: (___) ___-_____

Primary Care Doctor: _____ Who referred you to us? _____

Pharmacy: _____ Location: _____ Phone #: (___) ___-_____

Is there a family member or other person you would like for us to share your medical information?
_____ Yes Name(s) _____

_____ No

Who is responsible for payment? _____ Relationship to patient? _____

Address: _____ City/State: _____ Zip: _____ Phone #: (___) ___-_____

Insurance Information
Primary Insurance Company Name: _____

Address: _____ City/State: _____ Zip: _____ Phone #: (___) ___-_____

Insured Name: _____ Date of Birth _____ Employer _____

Contract # _____ Group # _____
Secondary Insurance Company Name: _____
Address: _____ City/State: _____ Zip: _____ Phone #: (___) ___-_____
Insured Name: _____ Date of Birth _____ Employer _____
Contract # _____ Group # _____

Revised December 2011