MID PLAINS PODIATRY, PC
11071 WEST MAPLE ROAD
OMAHA, NE 68164
402-315-4344

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 CAN WE CONTACT YOU AT THIS NUMBER? LEAVE A MESSAGE?
WORK PHONE #: (____) ____-_______ YES NO CAN WE CONTACT YOU AT THIS NUMBER? LEAVE A MESSAGE?
CELL PHONE #: (____) ____-________ YES NO CAN WE CONTACT YOU AT THIS NUMBER? LEAVE A MESSAGE?

E-MAIL: _________________________________ THIS IS ONLY USED FOR WHEN WE HAVE PRODUCT SALES OR NEWS.
PRIMARY LANGUAGE: _____________________ RACE: ____________
ETHNICITY: HISPANIC __________ NON HISPANIC ________ DECLINE ________

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: FIRST: ______________ LAST: _____________ DATE LAST SEEN: __________________
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 APRIL 2014