657 Camino De Los Mares #133
San Clemente, CA. 92673
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PATIENT INFORMATION SHEET

NAME _____GENDER/PRONOUNS_____ D.O.B.____/____/_____

HOME ADDRESS_____CITY_____

STATE____ZIP CODE_____ PHONE# (_____) _____ ALT PHONE # (_____)_____

EMAIL ADDRESS:_____

WHO REFERRED YOU TO THIS OFFICE? _____

PRIMARY CARE DOCTOR _____PRIMARY CARE PHONE # (_____)_____

REASON FOR TODAYS VISIT: _____

ARE YOU DIABETIC? YES__NO __ ARE YOU ON DIALYSIS? YES__ NO__ DAYS? M__T__ W__TH__F__ S__

MEDICATIONS:_____

ALLERGIES TO MEDICATION/ LATEX?_____

EMERGENCY CONTACT NAME: _____

RELATION TO PATIENT: _____ PHONE # (_____) _____

PREFERRED PHARMACY:_____

HOW WOULD YOU LIKE TO BE REMINDED OF YOUR APPOINTMENTS? PHONE____TEXT____EMAIL_____

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DO YOU HAVE MEDICAL INSUANCE? YES___ SELF PAY____ SOCIAL SECURITY NO:_____

PRIMARY INSURANCE: _____ POLICY NUMBER:_____

SECONDARY INSURANCE:_____POLICY NUMBER:_____

I AUTHORIZE PACIFIC COAST PODIATRY, PC TO BILL MY INSURANCE ON MY BEHALF. I ALSO AGREE TO PAY ALL CHARGES FOR SERVICES RENDERED BY PACIFIC COAST PODIATRY NOT COVERED BY THE ABOVE NAMED INSURANCE COMPANY.

PATIENT SIGNATURE: _____ DATE _____/_____/_____

RELATIONSHIP TO PATIENT:_____