PODIATRY ASSOCIATES OF TEXAS

1186 W. Pioneer Pkwy, Arlington, TX. 76013 Phone: 817-7044223 Fax: 817-9843970

Patient Intake Form

PATIENT NAME: (Last)..... (first)..... (MI).....

ADDRESS: .....

APT/BLDG#

CITY: .... STATE:..... ZIP:.....

PATIENT PHONE: ..... IS THIS THE NUMBER TO CALL WHEN MAKING APPT: (Y) (N)

DATE OF BIRTH: ..... GENDER: (M) (F)

MARITAL STATUS: *Single* *Married* *Widowed* *Divorce*

Email:.....

Emergency Contact Name: ..... Phone:.....

Relationship:.....

DOES THE PATIENT HAVE POA /GUARDIAN: YES NO (SKIP THIS SECTION) LEGAL STATUS:

NAME:..... RELATIONSHIP

ADDRESS..... APT/BLDG#.....

CITY:..... STATE:..... ZIP: .....

POA/GUARDIAN PHONE:..... NOTIFY BEFORE EACH VISIT: YES NO

MEDICARE Number:..... HMO INVOLVEMENT: YES NO

PART B ELEGIBILITY: YES NO

OTHER INSURANCE CARRIER: .....

POLICY NUMBER: ..... GROUP NUMBER:.....

TYPE OF POLICY: HMO PPO TRADITIONAL PFFS POS

Secondary/ Supplement Carrier:.....

Policy Number:..... Group Number.....

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Patient Intake Form

PATIENT MEDICAL PROBLEMS:.....

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IS THE PATIENT CURRENTLY BEING TREATED BY A PRIMARY CARE PHYSICIAN: YES NO

NAME OF PRIMARY CARE PHYSICIAN: .....

IS THE PATIENT CURRENTLY ON OR RECEIVING: HOSPICE HOME CARE AID SERVICES OTHER

NAME OF AGENCY PROVIDING SERVICES: .....

PHONE:.....

REFERRING PARTY: ..... PHONE NUMBER.....