

FOOT and ANKLE SPECIALISTS

DR. ANTHONY ROSALES, D.P.M.

DR. EDWARD L. WIEBE, D.P.M.

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(928) 774-4825

PATIENT INFORMATION SHEET

Last Name: _____ First Name/MI: _____

Address(street): _____ P.O.Box: _____

City: _____ State: _____ Zip: _____

Phone #: (____)____-____ Cell Phone: (____)____-____ Social Security #:____-____-____

Sex: Male or Female Marital Status _____ Birthdate:____/____/____ Age:_____

Height: _____ Weight: _____ Shoe Size: _____

Employer: _____ Address _____

Work Phone: (____)____-____ Occupation: _____

RESPONSIBLE PARTY (if other than patient): Wife Husband Parent Other

Last Name: _____ First Name/MI: _____

Address(street): _____ P.O.Box: _____

City: _____ State: _____ Zip: _____

Phone #: (____)____-____ Birthdate:____/____/____

Employer: _____

Work Phone: (____)____-____ Occupation: _____

PRIMARY INSURANCE (Need copy of insurance card, for filing):

Insurance Company: _____

Subscriber (if other than patient): _____

SECONDARY INSURANCE:

Insurance Company: _____

Subscriber (if other than patient): _____

Who referred you to our office? _____

Please describe your foot problem: _____

Please list any medications you are currently taking and any past or present medical conditions: _____

Primary care physician: _____ Date of last visit: _____

Does patient use: Tobacco _____ Alcohol _____ Drugs _____

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or DR. ANTHONY ROSALES or DR. EDWARD L. WIEBE as agreed upon at the time of treatment for services rendered. I assume responsibility for payment of my account, and will be responsible for all collection costs, court or attorney fees.

Signature: _____ Date: _____