

FLAGSTAFF FOOT DOCTORS

DR. ANTHONY ROSALES, 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 _____ Birthday ____ / ____ / ____ 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 #: () - _____ Birthday: ____ / ____ / ____
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 you foot problem: _____

List all medications you are taking: _____

List all Allergies to Medications: _____

List all Surgeries: _____

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 to myself, DR. ANTHONY ROSALES 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: _____