FLAGSTAFF FOOT DOCTORS

DR. ANTHONY ROSALES, D.P.M.
421 N Humphreys Street Flagstaff, Arizona 86001
(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:_____ Email _____
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:____/____/_____ SS# _____
Employer: _____
Work Phone:(____) _____ Occupation:_____

PRIMARY INSURANCE (Need copy of insurance card, for filing):
Insurance Company: _____
Subscriber (if other than patient): _____
Who referred you to our office? _____
Please describe your foot problem: _____
_____
List all medications you are taking:_____
List all medical history: _____
List all allergies to medications: _____
List all Surgeries:_____
Primary care physician: _____ Date of last visit:_____
Does patient use: Alcohol_____ Non-Prescription Drugs_____
Has patient ever been a smoker? (circle one) Current smoker Never smoker Former Smoker
Preferred Pharmacy (Name and Zip Code): _____

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. I will be responsible for all collection costs, interest, court or attorney fees.
Signature:_____ Date:_____