Foot & Ankle Clinic

Of Central Nebraska

Date:_____ **Patient Name**: _____
First Middle Last

Social Security #:_____ **Date of Birth**:_____ **Age**:_____

Gender: Male Female **Preferred Name**:_____

Street Address:_____ **Mailing Address**:_____

City:_____ **State**:_____ **ZIP**:_____

Marital Status: Single Married Widow Separated Divorced (Please circle one)

Home Phone:_____ **Mobile Phone**:_____ **May we Text**: Yes or No

Preferred Phone: Home or Mobile (Please circle one) **May we leave you a message**: Yes or No

EMAIL Address:_____

Employer:_____ **Employer Phone**:_____

Emergency Contact:_____ **Phone**:_____

Primary Insurance: _____ **Name of Insured (if other than self):** _____

Insured's Date of Birth (if other than self): _____ **Relationship to Patient**: Spouse or Parent

Name of Insured's Employer:_____ **Insured's Work Phone Number**:_____

Name of Person responsible for paying the bill (the Guarantor): _____
(For Patient's Under the age of 19 Only)

Guarantor's Date of Birth: _____ **Guarantor's Relationship**: _____

Guarantor's Address: _____ **Guarantor's Phone**: _____

Signature: _____ **Date:**_____
Patient or Patient's Guarantor if Minor