Welcome to...

HAYCOCK Foot & Ankle Center

Patient's Name: _____

Phone Number: _____

Cell Phone: _____

Address: _____

City: _____ State: ____ Zip: _____

Age: _____ Date of Birth: _____

Email Address: _____

Social Security Number: _____

Marital Status: (circle one)

Single Married Separated Divorced Widowed Child

Primary Place of Employment of Patient **or** Parent of Child

Place of Employment: _____

Address of Employer: _____

City: _____ State: ____ Zip: _____

Phone Number of Employer: _____

Employment Status: (circle one)

Full-Time Employment	Unemployed	Temporarily Disabled
Part-Time Employment	Retired	Homemaker
Self Employed	Disabled	Currently off Post-Op

Name of Spouse /Parent/Legal Guardian/Significant other:

_____

Phone Number: _____

Cell Phone: _____

Address: _____

City: _____ State: ____ Zip: _____

Emergency Contact Information: Name other than listed above

Name: _____ Relationship: _____

Phone Number: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

If this is a divorced or separated home, name of custodial residential parent on document: _____

County and state where document is filed: _____

If not living with person of legal custody, state name of person with whom child is living.

Name: _____ Relationship: _____

Phone Number: _____

Cell Phone: _____

Primary Insurance

Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Secondary Insurance

Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Additional Insurance

Insurance Company Name: _____

Policy Holder's Name: _____

Family Physician Name: _____

Phone # _____

City: _____ Date Last Seen: _____

Do you see a Cardiologist/Heart doctor: **YES or NO**

List Names of Additional Doctors Currently Seeing:

_____

_____

Please pick one from each section in bold

Race: ___ American Indian or Alaska Native ___ Asian
___ Black or African American ____ Other
___ Native Hawaiian or Other Pacific Islander ___ White

Ethnicity: ___ Hispanic or Latino OR ___ Not Hispanic or Latino

Primary Language: _____

Pharmacy Information

Primary Pharmacy : _____

Street Name: _____

City: _____

Secondary Pharmacy : _____

Street Name: _____

City: _____

Contact Preferences : Check all that apply

Email ___ Mail ___ Phone ___ Ok to leave message:

___ on answering machine ____ with person who answers phone

Workers Compensation

Is this a work related Injury? _____

Will you be filing this with Worker's Compensation? _____

Date of Injury: _____ Claim Number: _____

May release medical information to Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

It is patient's responsibility to call if medical release recipients change.

Thank you for choosing Haycock Foot & Ankle Center

2311 Baton Rouge Ave, Lima Ohio 45805 419 228 3338