Quad Cities Foot & Ankle Associates, P.C.

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Quad Cities Foot & Ankle Associates, P.C.
Patient Information Sheet

ACCT #_____ Date _____

Patient's Name:(First)_____(MI)_____(Last)_____ Sex: Male / Female

Social Security # _____Date of Birth _____ Age _____E-mail_____

Home Address _____Unit #_____ City_____ State _____Zip_____

Home Phone _____Work Phone _____Mobile Phone _____

Occupation _____Employer / School _____ Full Time/ Part Time (Circle One

Work Address _____ City_____State ____ Zip_____

Emergency Contact: Name_____Relation _____ Phone _____

If the above patient is **a child, has a legal guardian, has a spouse, or is not responsible for the bill**, please provide the information requested in this section below:

__ Parent of Child __ Legal Guardian __Spouse __ Other Party Responsible for Bill

Full Name _____Date _____

Social Security # _____Age _____ Date of Birth _____ Sex: Male / Female

Home Phone _____Mobile Phone _____ Work Phone _____

Home Address _____Unit #_____ City_____ State ____ Zip_____

Do You Have Health Insurance Coverage? Yes / No If Yes, Please Provide Information Below, and Give Card to Office Staff:

Name of Insured Person _____

Social Security # of Insured Person _____Date of Birth of Insured Person _____

Full Name of Primary Insurance _____

Policy and Other ID #'s _____

Full Name of Secondary Insurance _____

Policy and Other ID #'s _____

How Did You Hear About Our Practice? _____

If You Were Referred by Another Doctor or Doctor's office, Please Provide Name, Address, and Phone Number:

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