ILLINOIS
Foot & Ankle
CENTER
Kelly N. May, DPM, FACFAS

PATIENT REGISTRATION

Patient Name: _____ Gender: □ Male □ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____

Marital Status: □ Single □ Married □ Widowed

Preferred Phone: _____ □ Home □ Cell □ Work

Alternate Phone: _____ □ Home □ Cell □ Work

Email Address: _____

Appointment Reminders: □ Email □ Text □ Office Call □ Voice reminder

Employer: _____ Occupation: _____

Primary Doctor: _____

Emergency Contact Person: _____
Relationship: _____
Phone Number: _____

DEMOGRAPHICS

Preferred Language: □ English □ Spanish □ Polish □ Other: _____

Race: □ African American □ Asian □ Caucasian □ Hispanic/Latino □ Other: _____

HOW DID YOU HEAR ABOUT US?

□ Family/Friend: _____ □ Google/Internet □ Insurance Company
□ Doctor Referral □ Drive-by □ Other: _____

PHARMACY

Name: _____ Intersection/City: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

INSURANCE INFORMATION

If policyholder is someone other than patient

INSURANCE

Primary: _____
Name of policyholder: _____
DOB: _____
Address: _____
City: _____ State: ___
Zip code: _____
Phone Number: _____
Relation to Patient: □ Spouse □ Parent □ Other

Secondary: _____
Name of policyholder: _____
DOB: _____
Address: _____
City: _____ State: ____
Zip code: _____
Phone Number: _____
Relation to Patient: □ Spouse □ Parent □ Other

GUARANTOR ****Person ultimately responsible for bills****

□ Patient

□ Policyholder of insurance (above)

□ Other: Name: _____

Address: _____

City: _____ State: ____ Zip code: _____

Phone Number: _____