

**PUEBLO ANKLE AND FOOT CARE, PLLC  
WELCOME TO OUR OFFICE**

**PLEASE ANSWER ALL QUESTIONS AS THIS INFORMATION IS IMPORTANT FOR YOUR HEALTH AND OUR RECORDS**

NAME \_\_\_\_\_ M\_\_ F\_\_ SINGLE\_\_ MARRIED\_\_ DIVORCED\_\_ WIDOWED\_\_  
SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
HEIGHT \_\_\_\_ ' \_\_\_\_ " WEIGHT \_\_\_\_\_ AGE \_\_\_\_\_ RACE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE \_\_\_\_\_ ID NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
SECONDARY INSURANCE \_\_\_\_\_ ID NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
INSURED'S EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
SOCIAL SECURITY# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*I the patient realize it is my responsibility to pay for any service rendered. A monthly billing charge will be added to all accounts over sixty days. I authorize Dr. Benjamin Marble to release and obtain medical information as required for my treatment and processing of my insurance claim. I request that payment of my insurance benefits be made on my behalf to PUEBLO ANKLE AND FOOT CARE PLLC.* SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**IF SIGNATURE OTHER THAN PATIENT** \_\_\_\_\_  
(PLEASE PRINT NAME) (RELATIONSHIP TO PATIENT)  
PATIENT FAMILY PHYSICIAN \_\_\_\_\_ LAST VISIT \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? PHONE BOOK \_\_\_ DEX \_\_\_ FAMILY MEMBER \_\_\_ FRIEND \_\_\_

NAME OF PERSON WHO REFERRED YOU? \_\_\_\_\_

**PODIATRIC INFORMATION**

In your own words describe your foot problem or complaint: \_\_\_\_\_  
\_\_\_\_\_. How long have you had this condition/problem? \_\_\_\_\_. Is this due to an injury? \_\_\_\_  
If yes, where did the injury occur: Home \_\_\_ Work \_\_\_ Other \_\_\_ Date of Injury \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Have you ever had foot or leg surgery? \_\_\_\_\_ Arch supports \_\_\_\_\_ Foot/Ankle x-rays \_\_\_\_\_ Other foot treatment \_\_\_\_\_  
Former Podiatrist \_\_\_\_\_ Shoe size \_\_\_\_\_