Wilks Advanced Foot Care
G. Jason Wilks, DPM, PC

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female
First Name MI Last Name
Preferred Name: _____

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

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Mailing Address: _____ **City/St/Zip** _____

Physical Address: _____ City/St/Zip _____

Home Phone#: (___)_____ **Cell Phone#:** (___)_____ **Work Phone#:** (___)_____

Preferred communication: home phone, cell, work, text

Email address: _____
By providing your email, you agree to receive information such as visit summaries, patient education, occasional updates and newsletters from our office. You can opt out anytime.

Primary Care Provider: _____ **Pharmacy**:_____

Employer: _____ Occupation: _____

Spouse: _____ **DOB**: _____ **Social Security**#: _____

Spouse Employer: _____ Phone#: (___)_____

Do you have an advanced directive or advanced care plan? YES NO (if yes, please provide us a copy)

If someone other than the PATIENT is responsible for payment, complete the following:
Name of responsible party: _____ Relationship to patient: _____
Address: _____ City/St/Zip _____
Home Phone#: (___)_____ Cell Phone#: (___)_____ Work Phone#: (___)_____
Birthdate: _____ Social Security#: _____ Employer: _____

How do you intend to pay? ☐ Cash ☐ Check ☐ Visa/MasterCard ☐ Insurance ☐ Other

Primary Insurance: _____ Phone#: (___)_____
Name of Insured: _____ DOB: _____ SSN: _____
Policy #: _____ Group#: _____

Secondary Insurance:_____Phone#: (___)_____

Name of Insured: _____ DOB: _____ SSN: _____
Policy #: _____ Group#: _____

Patient Signature: _____ Date: _____