Podiatry Associates of IN, P.C.
Foot and Ankle Institute

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Tarick I. Abdo, DPM
Daniel S. Miller, DPM

Mr. Mrs. Miss Ms Dr. (Circle) Male / Female (Circle) married / single / widowed / divorced (Circle)

Last Name **First** **M.I.** Social Security # Date of Birth / Age

Street Address Apt # City / State Zip Code
Is this a nursing home address? YES / NO (Circle)

Home Phone # Cell Phone # Work Phone # Drivers License #

Spouse Name Emergency Contact Name & Phone Number / Relationship to Patient

Patient's Employer Street Address City / State Zip Code

Primary Care Physician's Name & Address City / State Zip Code Phone Number

Referred By: Physician / Established Patient / Friend / Phone Book / Internet / Insurance Book (Circle) Name:

► **(If Patient is a Minor)** Responsible Parties Name & Address **(Person in office w/ minor)** City / State Zip Code

Responsible Parties Home # Responsible Parties Work # Responsible Parties Social Security # Date of Birth

Responsible Parties Employer Name & Address City / State Zip Code

► **Primary Insurance Carrier** Policy Holder's Name Member ID # / Group #

Policy Holder's Address (if different from patient's / responsible parties) City / State Zip Code

Policy Holder's Home Phone # Policy Holder's Work Phone # Policy Holder's Social Security # Date of Birth

Policy Holder's Employer Name & Address City / State Zip Code

► **Secondary Insurance Carrier** Policy Holder's Name Member ID # / Group #

Policy Holder's Address (if different from patient's / responsible parties) City / State Zip Code

Policy Holder's Home Phone # Policy Holder's Work Phone # Policy Holder's Social Security # Date of Birth

Policy Holder's Employer Name & Address City / State Zip Code