1762 N. Waterman Dr.
San Bernardino, CA 92404
TEL: (909) 886-3668
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Clayton G. Johnsen, DPM
Foot Clinic

PATIENT INFORMATION SHEET

TODAY'S DATE ____/____/_____

NAME ____ DATE OF BIRTH ____/____/_____

HOME ADDRESS ___________________________ CITY________________________ ZIP CODE__________

PHONE # (_____) __________________ ALTERNATE PHONE # (optional) (_____) _____________________

WHO REFERRED YOU TO THIS OFFICE? ____

PRIMARY CARE DOCTOR ____

PRIMARY CARE OFFICE PHONE NUMBER ____

WHAT IS YOUR FOOT PROBLEM? ____

ARE YOU IN GENERAL GOOD HEALTH? YES_____________________ NO ____________________

DO YOU HAVE DIABETES? YES_____________________ NO ____________________

ARE YOU ON DIALYSIS? IF YES, WHAT DAYS? ____

ARE YOU ALLERGIC TO ANY TYPE OF MEDICATION? ____

EMERGENCY CONTACT NAME ____

RELATION TO PATIENT:__________________________ PHONE # (_____) ____________________________

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DO YOU HAVE ANY KIND OF INSURANCE? YES____________________ NO ____________________

NAME OF INSURANCE COMPANY ____

INSURANCE I.D. NUMBER ____

I AUTHORIZE PACIFIC COAST PODIATRY TO BILL MY INSURANCE ON MY BEHALF. I ALSO AGREE TO PAY ALL CHARGES FOR SERVICES RENDERED BY PACIFIC COAST PODIATRY NOT COVERED BY THE ABOVE NAMED INSURANCE COMPANY.

PATIENT SIGNATURE: ____ DATE _____/_____/_____