Foothills Podiatry, PLLC
R. Brent Harbin, DPM
David L. Franklin, DPM
Foot and Ankle Disorders

# Patient Information Sheet

**Please print clearly and fill out completely:**

Date_____

**Patient Information**:

Name of Patient:_____
Last First Middle

Address_____
Street / PO Box City State Zip

Date of Birth_____ Age_____ Sex_____ Marital Status_____

SS#_____ Home Phone (____)_____ Cell Phone(____)_____

Employer_____ Occupation_____

Address_____ Work Phone(____)_____

**Spouse/Parent Information**:

_____ Date of Birth_____
Last First Middle

_____
(Address: if different from above) Street / PO Box City State Zip

Relationship to Patient_____ SS#_____

Employer_____ Work Phone(____)_____

**In Case of an Emergency:** (someone other than your spouse or living in your household)

Name_____ Relationship_____ Phone(____)_____

Family Doctor_____ Phone(____)_____

Local Pharmacy_____ Address_____

Whom may we thank for referring you_____

I consent to allow Dr. Harbin/Dr. Franklin to assess and treat my foot or ankle condition. I authorize the release of any medical information necessary to process this claim. I agree to accept responsibility for payment of all charges regardless of any insurance coverage. I request that payment of authorized insurance benefits be made either to me or on my behalf to Dr Harbin/Dr Franklin for any services furnished to me by Dr Harbin/Dr. Franklin.

Signature_____