Richmond Foot and Ankle Clinic

36640 Heritage Drive • Richmond, MI 48062
Phone: (586) 727-7867 • Fax: (586) 727-5598

Hengelberth D. Montufar, D.P.M., F.A.C.F.A.S.

DATE:_____

PATIENT INFORMATION

PLEASE PRINT

LEGAL NAME:_____ _____ _____ **MALE:**____ **FEMAILE:**____
FIRST INITIAL LAST

ADDRESS:_____ _____ _____ _____
NUMBER & STREET CITY STATE ZIP

PHONE NUMBERS: ( )_____ ( )_____ ( )_____
HOME CELL WORK

MAILING ADDRESS (IF DIFFERENT):_____ _____ _____ _____
PO BOX CITY STATE ZIP

E-MAIL ADDRESS:_____

DATE OF BIRTH:_____ **PATIENT'S SOCIAL SECURITY NUMBER:**_____

EMPLOYER:_____ **HOW DID YOU HEAR ABOUT OUR OFFICE:**_____

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

RACE: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK/ AFRICAN AMERICAN/NATIVE ☐ HAWAIIAN
☐ WHITE/ CAUCASIAN ☐ MORE THAN ONE RACE ☐ OTHER PACIFIC ISLANDER

EMERGENCY CONTACT NAME:_____ **PHONE:**_____

PRIMARY PHYSICIAN:_____ **ADDRESS:**_____ **PHONE:**_____

PREFERRED PHARMACY:_____ **PHARMACY CITY:**_____

ALL INSURANCE INFORMATION MUST BE FILLED IN

PRIMARY INSURANCE CO:_____ **CARDHOLDER NAME:**_____
CARDHOLDER DATE OF BIRTH:_____ **RELATIONSHIPT TO PATIENT:**_____
CARDHOLDER EMPLOYER:_____ **INSURANCE ID#:**_____ **GROUP#:**_____
CARDHOLDER SOCIAL SECURITY NUMBER:_____

SECONDARY INSURANCE CO:_____ **CARDHOLDER NAME:**_____
CARDHOLDER DATE OF BIRTH:_____ **RELATIONSHIPT TO PATIENT:**_____
CARDHOLDER EMPLOYER:_____ **INSURANCE ID#:**_____ **GROUP#:**_____
CARDHOLDER SOCIAL SECURITY NUMBER:_____

PRINTED NAME OF PARENT OR GUARDIAN WHO BROUGHT MINOR IN:_____
SIGNED NAME OF PARENT OR GUARDIAN WHO BROUGHT MINOR IN:_____

VISIT RELATED TO A WORK INJURY: YES_____NO_____ **AUTO INJURY:** YES_____NO_____
IF WORK OR AUTO INJURY SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK