



David H. Warby DPM
Surgical and Medical Treatment of the Foot and Ankle



Patient

Patient First Name		Middle Initial	Last name		Name goes by:
Patient Address: Street			City	State	Zip Code
Mailing Address: (Use only if different than physical address)			City	State	Zip Code
Patient Date of Birth		Age	Patient Social Security Number		<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone	Other phone	Spouse	Patient Marital Status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed		
Father Name (if patient is a minor)			Mother Name (if patient is a minor)		
Emergency Contact Name		Emergency Contact Phone	Relationship to Patient		
Patients Employer		Employers Phone	Employers Address	Employment <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Spouses Employer if applicable		Employers Phone	Employers Address	Full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Guarantor (person who is responsible for payment)

Guarantor First Name		Middle Initial	Last name		Patients relationship to Guarantor
Guarantor Address: Street			City	State	Zip Code
Guarantor Date of Birth		Age	Guarantor Social Security Number		<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone	Other phone	Spouse	Marital Status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed		
Guarantors Employer		Guarantors Phone	Guarantors Address		
Spouse's Employer if applicable		Employer Phone	Employer Address		

Insurance: (please give the receptionist your cards so they may be scanned in as well)		
Primary Insurance:		Secondary Insurance:
Policy Holder:		Policy Holder:
ID#:		ID#:
Group:		Group:
Primary Care Physician and Phone	Did anyone refer you to our office? <input type="checkbox"/> yes <input type="checkbox"/> no Name:	Pharmacy name and city
How did you hear about our office?		
<input type="checkbox"/> Insurance plan: _____ <input type="checkbox"/> Insurance internet site <input type="checkbox"/> Insurance directory book <input type="checkbox"/> Insurance phone number <input type="checkbox"/> Advertisement. Which one? _____ <input type="checkbox"/> Other Physician: _____		
<input type="checkbox"/> Yellow pages. Which one? <input type="checkbox"/> Davis County Directory <input type="checkbox"/> Lakeview Directory <input type="checkbox"/> Northern Utah Directory <input type="checkbox"/> Yellow Book <input type="checkbox"/> Dex Directory <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Internet site: _____ <input type="checkbox"/> Other: _____		

I represent and affirm that the above information is true and correct and it is my understanding that this office is relying on the above information that I have provided. I hereby give permission to Dr. Warby and Associates to administer treatment, as may be deemed necessary in the diagnosis and treatment of my medical condition(s).

Signature: _____ Date: _____