



Wilks Advanced Foot Care
G. Jason Wilks, DPM, PC

PATIENT INFORMATION

Patient Name: _____ Male
Female

First Name MI Last Name

Preferred Name: _____

Date of Birth: _____ **Social Security #:** _____

Marital Status (check one): Single Married Divorced Separated Widowed

Mailing Address: _____ **City/St/Zip** _____

Physical Address: _____ **City/St/Zip** _____

Home Phone#: () _____ **Cell Phone#:** () _____ **Work Phone#:** () _____

Preferred communication: home phone, cell, work, text

Email address: _____

By providing your email, you agree to receive information such as visit summaries, patient education, occasional updates and newsletters from our office. You can opt out anytime.

Primary Care Doctor: _____

Pharmacy: _____

Do you have an advanced directive or advanced care plan? YES NO (if yes, please provide us a copy)

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party: _____ Relationship to patient: _____

Address: _____ City/St/Zip _____

Home Phone#: () _____ Cell Phone#: () _____ Work Phone#: () _____

Birthdate: _____ Social Security#: _____ Employer: _____

How do you intend to pay? Cash Check Visa/MasterCard Insurance Other

Primary Insurance: _____ Phone#: () _____

Name of Insured: _____ DOB: _____ SSN: _____

Policy #: _____ Group#: _____

Secondary Insurance: _____ Phone#: () _____

Name of Insured: _____ DOB: _____ SSN: _____

Policy #: _____ Group#: _____

Patient Signature: _____ **Date:** _____