

Ritchie Steed, DPM•Flatirons Foot & Ankle Clinic•2130 W Mountain View Ave, #203•Longmont•CO•80501
303-772-7008
www.flatironsfoot.com

Name _____

Nickname _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____ Home phone() _____

Cell Phone() _____ Email: _____

Contact Preference: by phone: patient only, patient and/or spouse, anyone answering the phone
 by mail
 by email

Primary Language: English Spanish Other: _____

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

Ethnicity: Not Hispanic or Latino Hispanic or Latino

Birthdate: _____ Age _____ F() M() Marital Status: S M W D Other

Occupation: _____

Employed by: _____ Work Phone() _____

Work Address: _____

Person responsible for bill: _____ Social Security _____

Birthdate: _____ Phone: (if different from above) _____

Address (if different from above) _____

Insurance Policy Holder: _____ Birthdate: _____

Relationship to patient: _____

Address if different from above: _____

Emergency Contact: _____ Phone: _____

Personal Physician's Name: _____ Phone: _____

How did you find about our office? Your doctor Internet Phone book Friend Radio Newspaper Other

Who can we thank for referring you? Name _____

**Please know that we make every effort to keep your information private and do not share it without your consent. We are a near paperless medical office. All forms including this one that you fill out will be scanned electronically and placed in your electronic chart and then the paper forms will be shred and destroyed.

I have read the above statement and consent to the conversion of my paper forms to electronic forms in my electronic chart at Flatirons Foot & Ankle.

signature of patient date

*signature of parent/guardian date
(if patient is under age or requires legal guardian)