

**PARNASSUS HEIGHTS PODIATRY GROUP, INC.**

**2250 HAYES ST. SUITE 4-A**

**SAN FRANCISCO, CA 94117**

PLEASE PRINT THE FOLLOWING INFORMATION.  
THIS IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH.

**PATIENTS FULL NAME**

LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ SOC. SEC. NO.: \_\_\_\_\_

SEX: (M OR F): \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

**RESPONSIBLE PARTY FOR INSURANCE BILLING AND SERVICES:**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_

PHONE #: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**CONTACT IN CASE OF EMERGENCY:** \_\_\_\_\_

PHONE #: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**INSURANCE NAME:** \_\_\_\_\_ **NAME OF INSURED:** \_\_\_\_\_

**SUBSCRIBER/INSURED PARTY DATE OF BIRTH:** \_\_\_\_\_

**SUBSCRIBER/MEMBER #:** \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ **NAME OF INSURED:** \_\_\_\_\_

**SUBSCRIBER/MEMBER #:** \_\_\_\_\_ **SUBSCRIBER D.O.B:** \_\_\_\_\_

**REFERRING DOCTOR/INDIVIDUAL:** \_\_\_\_\_

**FAMILY PHYSICIAN/PRIMARY CARE DOCTOR:** \_\_\_\_\_

**PCP PHONE #:** \_\_\_\_\_ **LAST DATE SEEN:** \_\_\_\_\_

**PRESENT WEIGHT/HEIGHT:** \_\_\_\_\_ / \_\_\_\_\_ **SHOE SIZE:** \_\_\_\_\_

HAVE YOU EVER SEEN A PODIATRIST? (CIRCLE) YES NO

IF SO, WHERE? \_\_\_\_\_