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Podiatric Medicine & Surgery

Email \_\_\_\_\_

Patient Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Additional Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Marital Status S M W D

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouses Name, If Minor, Parent or Guardian \_\_\_\_\_

Husband/Wife Employed by \_\_\_\_\_

Family Physician \_\_\_\_\_

May we send a report of your Foot Evaluation to him/her? \_\_\_\_\_

Pharmacy \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Insurance Co. \_\_\_\_\_

Additional Medical Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Company \_\_\_\_\_

Policyholder's Name (if different than patient) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of person responsible for paying this account \_\_\_\_\_

Patient shoe size \_\_\_\_\_ Width \_\_\_\_\_ Patient Weight \_\_\_\_\_ Patient Height \_\_\_\_\_

Briefly describe your current foot problems \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

**Patients or Authorized Person's Signature**

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to Podiatry Associates when assignment is accepted.

Date \_\_\_\_\_ Signature \_\_\_\_\_

"People expect to get old - their teeth wear out and they get fillings and replacements; Their eyes wear out and they get glasses of all kinds; Their hearing wears out and they get hearing aids - but somehow people never expect their feet to wear out. The feet are supposed to go on forever and yet they work harder and under worse conditions than most everything. Your podiatrist considers walking a privilege. He is dedicated to keeping you walking in comfort."