Bay State Foot & Ankle Specialists, LLC
380 Lowell Street, Suite 102 Wakefield, MA 01880

Patient Demographic Form
Please PRINT

Date _____

Last Name_____ **First Name**_____ **Middle Initial**_____
Nickname/AKA_____

Date of Birth_____ **Gender** □ Male □ Female □ Other

Marital Status
□ Married □ Single □ Divorced □ Life Partner □ Separated □ Widowed

Language if other than English _____

Home Address_____ **Apt #**_____
City_____ **State**_____ **Zip Code** _____
Home Phone_____ **Cell Phone** _____

Email Address_____

Employment Status

□ Active Duty Military	□ Child	□ Disabled	□ Employed Full-Time
□ Employed Part-Time	□ Homemaker	□ Not Employed	□ Retired
□ Self Employed	□ Student Full-Time/ Part-Time		

Occupation _____

****Preferred Pharmacy**_____ **Address**_____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician _____ **Physician Address**_____

How did you hear about us?

□ Family Member	□ Friend	□ Internet _____
□ Insurance	□ Physician	□ Other _____

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RESPONSIBLE PARTY/INSURANCE GUARANTOR INFORMATION

Relationship to Patient
□ Self (If self, skip to Emergency / Next of Kin) □ Spouse □ Parent □ Other

Last Name_____ **First Name**_____
Relationship to Patient_____
Address _____ **Apt #** _____
City_____ **State**_____ **Zip Code**_____
Home Phone_____ **Cell Phone**_____

EMERGENCY CONTACT INFORMATION

(Please list a person we can contact in the case of a medical emergency that may occur in our office.)

Last Name_____ **First Name**_____

Relationship to Patient_____

Address _____ **Apt #** _____
City_____ **State**_____ **Zip Code**_____
Home Phone_____**Cell Phone**_____**Work Phone**_____

Are we allowed to share any of your medical information, test results with anyone other than yourself? Such as a parent, spouse or other family member or friend?

YES NO

If yes, please write the name(s) of those individuals:

_____

_____

Are we allowed to leave test results on the voicemail of the phone numbers listed in your chart?

YES NO