West Michigan Foot and Ankle PLLC
Alexus Squires DPM, AACFAS

Demographics

First Name:______________________ Last Name: _____________________ DOB: _____/______/______

Preferred Name: ______________________ Gender: __________ Age: _________ Shoe Size: ___________

Social Security #:__________-_________-__________ Email: ___________________________________

Cell Phone: _______________________________ Home Phone: __________________________________

Address:____

City: ________________________________ State: ______________ Zip: ___________________

Were you referred by one of our patients? Yes ☐ No ☐

If Yes, who referred you? We want to thank them! ____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Occupation:____________________

Emergency Contact Full Name: __________________________

Phone Number: ___________________ Relationship:___________________

Primary Care Doctor: ____________________________________ Date Last seen: _______________

Name of Pharmacy: _____________________________________ City/Zip Code: ________________

Primary Insurance Company Name: _______________________________________

Secondary Insurance Company Name: ______________________________________

Please provide cards to the receptionist so we can copy them to your patient chart.

The following information is only necessary if you are not the primary subscriber for your insurance

Responsible Party: Name _____________________________ DOB _____/______/______

Social Security Number____________________ (The person who supplies the patient's insurance or who is responsible for payment if uninsured).

Phone Number: _______________________ Relation to Patient: _________________________