Dr. Kennedy Legel, DPM, FACFAS
O 214-366-4600
F 214-366-4603
advancedFACS@gmail.com

Please complete all sections

PATIENT INFORMATION

Name:_____ Date of Birth:____/____/____
Last First Middle

Address:_____
Street City State Zip

Home phone:_____ Cell phone:_____

Email address:_____ Today's Date:_____

SSN:_____-_____-_____ Marital status: single married partnership divorced widowed

Spouse/Partner Name:_____ Spouse/Partner Employer:_____

PATIENT EMPLOYER INFORMATION

Employer name:_____

Address:_____
Street City State Zip

Work phone:_____ Contact person at work:_____

Is today's visit due to an injury at work? YES NO Personnel department notified? YES NO

INSURANCE INFORMATION

PRIMARY insurance company name: _____

ID/Member #:_____ Group name/number:_____

Effective date:_____ Expiration date: _____

Policy holder name:_____ Policy holder DOB:_____ Relationship:_____

SECONDARY insurance company name: _____

ID/Member #:_____ Group name/number:_____

Effective date:_____ Expiration date: _____

Policy holder name:_____ Policy holder DOB:_____ Relationship:_____

over please

POLICY HOLDER/RESPONSIBLE PARTY INFORMATION *(if different from above)*

Name:_____ Date of Birth:____/____/____
Last First Middle

Address:_____
Street City State Zip

Home phone:_____ Cell phone:_____

Email address:_____ SSN:_____-_____-_____

Patient relationship to policy holder:_____

MEDICAL PROVIDERS

Name of family physician:_____ City:_____ date last seen:_____

Name of former podiatrist:_____ City:_____ date last seen:_____

Pharmacy Name:_____ Phone:_____

Address:_____
Street City State Zip

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____
Last First Middle

Address:_____
Street City State Zip

Home phone:_____ Cell phone:_____ Work phone:_____