



Diana Emini, DPM
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PATIENT INFORMATION FORM

Last Name		First Name			MI
Address				City	
State	Zip Code	Age	Birth Date / /	Social Security # - -	
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Marital Status S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> DP <input type="checkbox"/>		Email		
Home Phone () -		Cell Phone () -		Work Phone () -	
Where can the physician leave you private health information?			Email <input type="checkbox"/>	Home <input type="checkbox"/>	Cell <input type="checkbox"/> Work <input type="checkbox"/>
Primary Care Physician		Phone () -		Last seen	
Pharmacy Name		Phone () -		Location	
Employer:		Address:			
How did you hear about us?		Internet search: Dex <input type="checkbox"/> Google <input type="checkbox"/> Local Podiatry <input type="checkbox"/> Other <input type="checkbox"/> _____			
Home Pages <input type="checkbox"/>	Homer Sun <input type="checkbox"/>	Insurance <input type="checkbox"/>	Lemont Reporter <input type="checkbox"/>	Suburban Life <input type="checkbox"/>	
Val Pak <input type="checkbox"/>	Walked-in/Drove by/Saw sign <input type="checkbox"/>	Westmont Progress <input type="checkbox"/>	Yellow Pages <input type="checkbox"/>		
Church Flyer <input type="checkbox"/> _____	Hospital <input type="checkbox"/> _____	Referral <input type="checkbox"/> _____			

PRIMARY INSURANCE INFORMATION

Primary Insurance Type		BCBS <input type="checkbox"/>	Medicare <input type="checkbox"/>	Aetna <input type="checkbox"/>	Cigna <input type="checkbox"/>	Other _____
Insured Name				Insured's DOB / /		
Insured's SSN - -		Relationship to insured		Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/> Other <input type="checkbox"/>
ID/Plan #		Group #			Co-Pay \$	

SECONDARY INSURANCE INFORMATION

Secondary Insurance (if applicable)		BCBS <input type="checkbox"/>	Medicare <input type="checkbox"/>	Aetna <input type="checkbox"/>	Cigna <input type="checkbox"/>	Other _____
Insured Name				Insured's DOB / /		
Insured's SSN - -		Relationship to insured		Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/> Other <input type="checkbox"/>
ID/Plan #		Group #			Co-Pay \$	

IN CASE OF EMERGENCY

Please contact	Relationship	Phone Number () -
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