Foot Care Associates of Texas
Dr Michael Wynn
23972 A Hwy 59 North Kingwood, TX 77339

*Form is for patients under 21(or on parents insurance plan)

Patient Name _____ Gender ◯ M ◯ F
First Middle Last

Childs SS# _____ Date of Birth ____/____/____
SS# IS REQUIRED BY INSURANCE TO FILE IF WE DON'T HAVE SS# YOU ARE LIABLE FOR FULL PAYMENT AT TIME OF SERVICE

Address _____
Apt #

_____
City State Zip Childs Phone #

Mother's Name _____ SS# _____ Date of Birth ____/____/____
Employer _____ Occupation _____
Address _____ Email _____
Apt#

_____
City State Zip

Home Phone: _____ Work _____ Cell _____

Father's Name _____ SS# _____ Date of Birth ____/____/____
Employer _____ Occupation _____
Address _____ Email: _____
Apt#

_____
City State Zip

Home Phone: _____ Work _____ Cell _____

Height _____ Weight _____ Shoe Size _____ Primary Language _____
Race ◯ American Indian ◯ Asian ◯ Hispanic or Latino ◯ Native Hawaiian or Other Pacific ◯ White ◯ Black or African American

Who can we notify about your appointments and release medical information to?

_____
Name Relationship Phone

Who is primary insurance carried under?

_____
Name Relationship SSN#

Emergency Contact

_____
Name Relationship Phone Number

Primary Physician _____ Last Date Seen ____/____/____

Former Podiatrist if any _____

How did you hear of us? ◯ Insurance ◯ Internet ◯ Insurance ◯ Sign ◯ Phone Book ◯ Patient ◯ Other

If referred by a Doctor, whom may we thank? _____

Patient Name (print) _____ Signature _____

Parent or Authorized Representative (print, if applicable) _____ Date _____