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

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

Patient Name _____ Gender ◯ M ◯ F
First Middle Last

Childs SS# _____ Date of Birth ____/____/____

Address _____
Apt #

_____
City State Zip

Fathers Name_____SS#_____ Date of Birth____/____/____
Employer _____ Occupation _____
Address _____
Apt #

_____
City State Zip

Home Phone:_____ Work _____ Cell _____

Mothers Name_____SS#_____ Date of Birth____/____/____
Employer_____Occupation_____
Address _____
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?

_____
Name Relationship

Who may we release your medical information to?

_____
Name Relationship

Emergency Contact

_____
Name Relationship Phone Number

Primary Physician _____ Last Date Seen ____/____/____

Former Podiatrist _____

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 _____