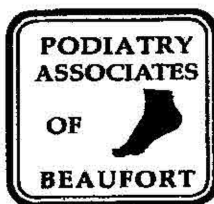
Michael C. Edwards, DPM
Trenton K. Statler, DPM



Podiatric Medicine & Surgery

Patient Name: ______________________________ ◯Male ◯Female

Home Address: ______________________ City ______________ State______ Zip __________

Mailing Address: ______________________ City ______________ State______ Zip __________

Primary Phone Number: ____________________ Secondary Phone Number: ________________

DOB: __________ Age: _____ SS#________________ Email Address: ____________________

Employer: __________________ Occupation: ________________ Work Ph# ______________

Primary Care Physician: __________________________ May we send reports to him/her? ◯Yes ◯No

Pharmacy: ____________________ City: ______________ Pharmacy Ph# ______________

Do you have medical insurance? ◯Yes ◯No Primary Insurance: ______________________

Do you have secondary medical insurance? ◯Yes ◯No Secondary Insurance: ________________

Policy holder's Name (if other than patient) ______________________ DOB: ______________

Name of person responsible for paying this account: ________________________________

Who may we thank for referring you to our office? __________________________________

Patient or Authorized Person's Signature

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to Podiatry Associates when assignment is accepted.

Signature ____________________________________ Date ______________________

"People get old – their teeth wear out and they get fillings and replacements; their eyes wear out and they get glasses of all kinds; their hearing wears out and they get hearing aids – but somehow, people never expect their feet to wear out. The feet are supposed to go on forever, and yet, they work harder and under worse conditions than most everything. Your podiatrist considers walking a privilege. He is dedicated to keeping you walking in comfort."