

**Northeast Wisconsin Foot and Ankle Associates  
PATIENT REGISTRATION**

Today's Date: \_\_\_\_\_ Patient of:  Dr. Tougas  Dr. Schinke

Patient Name \_\_\_\_\_ Gender:  M  F

First MI Last  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Email \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Family Physician \_\_\_\_\_ Date Last Seen \_\_\_/\_\_\_/\_\_\_

Primary Language \_\_\_\_\_

Race\*:  Native American  Asian  African American  White

Ethnicity\*:  Hispanic or Latino  Not Hispanic nor Latino  Not Specified

(\*categories for race and ethnicity are determined by the federal government and are required for federal reporting purposes)

How did you hear about our office? (check all that apply)

Dr Referral  Patient Referral  Health Expo  Seminar  Website  Internet  Radio  Newspaper  
 Phone book  Other \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Authorization # \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Partner

Name of Spouse/Partner: \_\_\_\_\_

Student Status:  Full time Student  Not a student  Part time Student

Employment Status:  Employed Full time  Employed Part time  Not Employed

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Patient's Legal Rep: \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

How would you prefer to be contacted? (check all that apply) :  Phone  E-Mail

OK to leave messages with:  Patient only  Patient or spouse/partner  Anyone who answers phone

Preferred Pharmacy: \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ Location (Street, City) \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date Of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date Of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Is This a Workman's Comp. Case?  Yes  No If Yes, Date of Injury: \_\_\_\_\_

Workman's Comp. Carrier: \_\_\_\_\_