



Dr. Kennedy Legel, DPM, FACFAS
O 214-366-4600
F 214-366-4603
advancedFACS@gmail.com

Please complete all sections

PATIENT INFORMATION

Name: _____ Date of Birth: ____/____/____
Last First Middle

Address: _____
Street City State Zip

Home phone: _____ Cell phone: _____

Email address: _____ Today's Date: _____

SSN: _____-_____-_____ Marital status: single married partnership divorced widowed

Spouse/Partner Name: _____ Spouse/Partner Employer: _____

PATIENT EMPLOYER INFORMATION

Employer name: _____

Address: _____
Street City State Zip

Work phone: _____ Contact person at work: _____

Is today's visit due to an injury at work? YES NO Personnel department notified? YES NO

INSURANCE INFORMATION

PRIMARY insurance company name: _____

ID/Member #: _____ Group name/number: _____

Effective date: _____ Expiration date: _____

Patient relationship to policy holder: _____ Policy holder name: _____

SECONDARY insurance company name: _____

ID/Member #: _____ Group name/number: _____

Effective date: _____ Expiration date: _____

Patient relationship to policy holder: _____ Policy holder name: _____

over please

POLICY HOLDER/RESPONSIBLE PARTY INFORMATION (if different from above)

Name: _____ Date of Birth: ____/____/____
Last First Middle

Address: _____
Street City State Zip

Home phone: _____ Cell phone: _____

Email address: _____ SSN: _____ - _____ - _____

Patient relationship to policy holder: _____

MEDICAL PROVIDERS

Name of family physician: _____ City: _____ date last seen: _____

Name of former podiatrist: _____ City: _____ date last seen: _____

Pharmacy Name: _____ Phone: _____

Address: _____
Street City State Zip

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Last First Middle

Address: _____
Street City State Zip

Home phone: _____ Cell phone: _____ Work phone: _____