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PATIENT INFORMATION

Date _____
Name (First) _____ (MI) _____ (Last) _____
Soc. Sec # _____ Birthdate _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Sex M F Single Married Divorced Widowed Separated

Employer _____ Business Phone _____
Business Address _____ Occupation _____

In case of emergency who should be contacted? _____
Phone _____

Person responsible for account _____
Relationship to patient _____ Birthdate _____ Soc. Sec# _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible party employed by _____ Occupation _____
Business Phone _____ Business Address _____

Whom may we thank for referring you? _____

Where did you hear about us? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Brazil Times Ad | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Tribune Star Ad | <input type="checkbox"/> Friend/family member |
| <input type="checkbox"/> Wabash Valley Extra | <input type="checkbox"/> other _____ |

PRIMARY INSURANCE -

SECONDARY INSURANCE -

ADDITIONAL INSURANCE -

Name of Doctor who follows your diabetes: _____

Date of last visit with this diabetes Doctor: _____

How often do you check your blood sugar at home? _____

Blood sugar this morning? _____ Last HgA1C (3 month test) _____