Allen Foot Doctors, partner of StrideCare

Neha Singh, DPM, FACFAS and Sahil Handa, DPM

Patient Name____
(Last) (First) (Middle)

Address____
(Street) (City) (State) (Zip)

Cell Phone #_______________________________ Other phone #__________________

Email____

Date of Birth___________________ Age _________ Marital Status: M [ ] S [ ] D [ ] W [ ]

Driver's License #____

How did you hear about us? (Please be specific)___________________________________

Pharmacy Name you utilize____

Pharmacy location (Cross streets and City)______________________________________

IF YOU PLAN TO USE HEALTH INSURANCE TO HELP PAY FOR OUR SERVICES, PLEASE PRESENT YOUR ID AND INSURANCE CARD TO THE FRONT DESK.

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*I hereby give permission to the doctors to examine and administer treatment, after consultation, and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot/ankle condition.

Signature of Patient/Guardian____

Date____

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Allen, TX 75013

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Fax: 972-767-3614
Email: contactus@allenfootdoctor.com

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