Patient No.________

PATIENT INFORMATION

PLEASE PRINT CLEARLY

TODAY'S DATE____________

Patient's Last Name____________________ First Name______________ M.I.________ Age________ Sex______

Birthdate:____________________ Marital Status: ☐ S ☐ M ☐ W ☐ D

Social Security #:______________ Home Phone No.:______________ Cell Phone No.:______________

Home Address:______________________________ E-mail Address:______________

City:______________________________ State:____________ Zip Code:____________

Patient's Occupation:____________________ Patient's Employer:____________________

Employer's Address:____________________ Phone No.:______________ Ext.:______

(If patient is a ***MINOR****, please give name of parent or guardian, who is financially responsible for billing.)*

Name of Spouse/Parent:______________________________ Birthdate:________

Spouse's/Parent's Employer:______________________________

Employer's Address:____________________ Phone No.:______________ Ext.:______

OTHER INFORMATION

Primary Care Physician (MD) Name & Address ______________________________

____

How were you referred to our office? ☐ Primary Care Physician ☐ Another Physician (Name:______________)

☐ Yellow Pages ☐ Friend or relative ☐ Health Insurance Co. ☐ Other______________

In Case of an emergency notify____________________ Relationship____________ Phone__________

ACCIDENT INFORMATION

Accident related to ☐ Work ☐ Auto ☐ Other______________________________

List date of injury and brief description of accident______________________________

____

Responsible party (Name and Address) ______________________________

____

INSURANCE INFORMATION

Primary Company ______________________ Secondary Company ______________________

ID Number ______________________ ID Number ______________________

Group Number ______________________ Group Number ______________________

Subscriber Name ______________________ Subscriber Name ______________________

Subscriber Date of Birth ______________________ Subscriber Date of Birth ______________________

Subscriber Employer ______________________ Subscriber Employer ______________________

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONISTS TO COPY FOR YOUR FILE.

Continue on back side →

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Ankle & Foot Care.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Signed :______________________________ Date:____________

Witness: ______________________________ Date:____________

MEDICARE AUTHORIZATION STATEMENT

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services."

Beneficiary Signature: ______________________________

Date:____________________

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to

______________________________ *any information needed to*
(Name of Medigap Insurer)
determine these benefits or the benefits payable for related service."

Signature:______________________________

Date:____________________