

# Patient Information

Please Print Clearly

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ Married?: Yes / No

Employer/School: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Status: Full / Part Time

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Primary Ins Name: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Ins Name: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

How were you referred to our office?: \_\_\_\_\_

## Receipt of Notice of Privacy Practices:

I attest that I have received a copy of the Advanced Foot & Ankle Center's Notice of Privacy Practices.

The above address and phone may be used when contacting me:  Yes  No

You may leave a detailed message on my answering machine:  Yes  No

I grant permission to discuss my personal health information with the following person(s): *(please list names)*

## Insurance Assignment and Release:

I certify that I have insurance coverage with the above listed company and authorize Advanced Foot & Ankle Center PC to submit claims to my insurance company for any services rendered to me. I assign all insurance benefits to be paid directly to Advanced Foot & Ankle Center PC. I understand that I am financially responsible for all charges whether or not paid by insurance.

Advanced Foot & Ankle Center PC may use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will remain in effect for one year from the date signed below.

## Medicare/Medigap Authorization:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Advanced Foot & Ankle Center PC for any services furnished to me by that provider.

To the extent permitted by law, I authorize Advanced Foot & Ankle Center PC to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents, any information needed to determine these benefits or benefits for related services.

## Treatment Consent:

I hereby consent and give permission to the physicians of Advanced Foot & Ankle Center PC to evaluate, administer, and perform such procedures upon me, as the doctor deems necessary.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date