PATIENT INFORMATION SHEET

Welcome to our office

Please present your insurance card(s) and drivers license or state ID to our receptionist

Patient Last Name:_____ Legal First Name:_____ MI:____

Prefers to be called:_____

Patient Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

Email Address:_____

Gender □ Male □ Female Marital Status □ Single □ Married □ Widowed □ Divorced

Ethnicity □ Hispanic □ Non Hispanic

Race □ White □ American Indian or Alaska Native □ Asian □ Pacific Islander
□ Black or African American

How may we contact you? □ Telephone □ Email □ Text

When leaving a message: □ Patient Only □ Patient or Spouse □ Anyone

Referred by □ Friend □ Insurance □ Internet □ Newspaper □ Phone Book □ Doctor

Insurance Information

Name of Insurance:_____

Your claim is □ Compensable/Work Related □ Automobile □ Other Liability □ Not Applicable

Name of Subscriber:_____

Subscribers Address (if different than above):_____ City:_____

State:_____ Zip:_____

Subscribers Date of Birth: _____/_____/_____ and Social Security #_____-_____-_____

Employers Name:_____

Employer Address:_____ Phone (_____) _____-_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Primary Care Physician:_____ Office Phone (_____) _____-_____

For Minors:

Name of Responsible Party (if different than the subscriber):_____

Date of Birth _____/_____/_____ Social Security #_____-_____-_____

Address:_____City:_____State:_____Zip:_____

Phone (_____) _____-_____

Name person(s), if any, who can have access to your records/PHI or pick up items for you:

_____

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of any material fact may subject me to all fees for services and/or other liability. I also understand that I am to notify The Foot and Ankle Specialists immediately of any changes to the above information and annually upon the office's request.

Print Name of Patient or Legal Authorized Representative	Signature	Relationship to Patient	Date