

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Ht /Wt \_\_\_\_\_

Shoe Size \_\_\_\_\_ Marital Status \_\_\_\_\_ Patient's Soc Sec # \_\_\_\_\_ Home Phone# \_\_\_\_\_

Home Address \_\_\_\_\_ Apt/Floor# \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_ Cell Phone# \_\_\_\_\_ Occupation \_\_\_\_\_

Patient's Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Patient's **Primary** Insurance Name & ID# \_\_\_\_\_ Grp # \_\_\_\_\_ Effective Date \_\_\_\_\_

Claim Address for Insurance: \_\_\_\_\_

**Name of Insurance Holder/Relation:** \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

**How did you hear about our Practice?** \_\_\_\_\_

**IF internet plse specify which web site** \_\_\_\_\_

In Case of an Emergency, Please Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone # (must be different #) \_\_\_\_\_ Work Phone # \_\_\_\_\_

Family Physician:/Address \_\_\_\_\_ Last Date Seen \_\_\_\_\_ Phone \_\_\_\_\_

Former Podiatrist: \_\_\_\_\_ Reason & Date seen \_\_\_\_\_

List any Medications You Are Taking \_\_\_\_\_

List any Allergies to Medicine/Other \_\_\_\_\_

Are you Diabetic? \_\_\_\_\_ Have you had any operations or serious illnesses? \_\_\_\_\_

If So Please List: \_\_\_\_\_

Do you have, or ever had, any of the following? (Check, if yes)

- Anemia       Arthritis       Asthma       Tumors       Blood Clots       Epilepsy
- Poor Circulation     Sickle cell     Gout       Varicose Veins     GI Problems       HIV
- Strokes       Heart Disease     Hepatitis     Kidney Disease     High Blood Pressure     MRSA

**Reason to see the Dr. Today:**

**Chief Foot Complaint** \_\_\_\_\_

**Is this the result of an accident?** \_\_\_\_\_ If yes describe type /location /date \_\_\_\_\_

- I HEREBY GIVE MY PERMISSION TO THE PHYSICIAN OF FOOT & ANKLE CLINICS OF AMERICA TO ADMINISTER ANY NON-SURGICAL TREATMENT THAT MAY BE NECESSARY TO TREAT MY FOOT CONDITION. - I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES (WHETHER OR NOT COVERED BY THE INSURANCE COMPANY) I UNDERSTAND IT IS MY RESPONSIBILITY TO BE KNOWLEDGEABLE ABOUT MY INSURANCE PLAN AND IT'S COVERAGE - I UNDERSTAND THAT IF I RECEIVE A CHECK FROM MY INSURANCE COMPANY FOR SERVICES PROVIDED BY FOOT & ANKLE CLINICS OF AMERICA, I AM RESPONSIBLE FOR PAYING FOOT & ANKLE CLINICS OF AMERICA IMMEDIATELY. - **CO-PAYMENTS MUST BE PAID AT THE TIME OF SERVICE.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

AUTHORIZATION I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM.

◆ We need copies of **ALL INSURANCE CARDS and DRIVER'S LICENSE/ID**

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO FOOT & ANKLE CLINICS OF AMERICA, LLC

**MUST SIGN** Signature \_\_\_\_\_ Date \_\_\_\_\_

FACA STAFF That reviewed information \_\_\_\_\_