



**ANKLE AND FOOT**  
- CARE -

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.**

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## 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: \_\_\_\_\_

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## 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: \_\_\_\_\_

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