



Advanced Foot & Ankle Surgeons

Surgical/Medical Management of Foot & Ankle Conditions

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Patient Personal Information

pnrnd <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. First Name		Middle Name		Last Name		Employer or School			
Dr. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/>									
Home Address				Work/School Address					
City		State	Zip Code	City		State	Zip Code		
Home Phone		Birth Date / /		SEX <input type="checkbox"/> M <input type="checkbox"/> F	Work Phone		Employed by employer for: <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years		
Drivers License #		Expires			Primary Care/Family Physician		First Name Last Name		
E-Mail address for patient contact(optional)		Occupation		Student Retired		City Phone ()		Date Last Seen / /	

Insurance - Please present your insurance forms, cards and identification to the receptionist

Patient First Name Middle Name Last Name		Birth Date		AGE	Social Security Number:	
Primary Carrier Name <input type="checkbox"/> Medicare				Secondary Carrier Name <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid		
Claims Address				Claims Address		
City		State	Zip	City		State Zip
Phone ()		Auth ()		Phone ()		Auth ()
Employer or Group Name		Group Number		Employer or Group Name		Group Number
Insurance Name on I.D. Card		Birth Date		Insurance Name on I.D. Card		Birth Date
Member Policy ID or Social Security Number		Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Member Policy ID or Social Security Number		Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

Please tell us how you chose us to provide your medical care?

Who deserves a thank you for referring you to us? Name: _____		Otherwise, how did you learn about us?	
This person is a: <input type="checkbox"/> Friend <input type="checkbox"/> Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Our Patient <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Other		<input type="checkbox"/> Insurance Co. Provider List <input type="checkbox"/> Referral Service _____	
Location: _____		<input type="checkbox"/> Website _____ <input type="checkbox"/> Mail	
		<input type="checkbox"/> Newspaper/Magazine _____ <input type="checkbox"/> Brochure/Literature	
		<input type="checkbox"/> Verizon Yellow Pages <input type="checkbox"/> Saw name when passing by	
		<input type="checkbox"/> Yellow Book <input type="checkbox"/> Other _____	

Acknowledgement and Signature

The Responsible Parties whose signatures appear below agree as follows:

- The Doctor(s), Associate Doctor(s), and staff of the Medical Practice, named on this form and hereafter referred to as DOCTOR, are authorized to medically treat the patient named on this form.
- DOCTOR is authorized to collect, use and exchange Individually Identifiable Health Information (IIHI) consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patients' other health care providers, seek payment, carry out necessary business functions and mandated government reporting requirements. These situations and others, as well as your rights regarding this information are explained in our separate *Notice of Privacy Practices* provided to you.

Agreed to and accepted by the responsible parties:

X _____ / /
Signed by First responsible party (Patient or, if patient is under 18 years old, Parent, or Guardian; Spouse or other Guarantor).

X _____ / /
Signed by Second Responsible Party (If patient is under 18 years old, Second Parent, or Guardian; Spouse or other Guarantor).