

**FOOT & ANKLE SPECIALISTS-Bellevue
NEW PATIENT INFORMATION SHEET**

- Michael R Powers, DPM
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- Donald E Buddecke, DPM
- Shannon M Lensing DPM

Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.

| | | | | | |
|-----------------------------------|---|--|---|---|--|
| Patient's Social Security# | | Patient's Date of Birth: | | | |
| Patient's First Name: | | Middle Initial: | | Patient's Last Name: | |
| Racial Category | <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White/Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Choose Not To Tell | | Ethnicity | <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Choose Not To Tell | |
| | | | | Preferred Language | |
| Gender: | <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status: | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other | | |
| Mailing Address: | | | City/State/Zip | | |
| Home Phone: | <input type="checkbox"/> Pref Contact | Emergency Contact: | | | |
| Work Phone: | <input type="checkbox"/> Pref Contact | Relationship: | | | |
| Cell Phone: | <input type="checkbox"/> Pref Contact | Emergency Telephone#: | | | |
| Employer/Job Description | | Primary Physician & Location: | | | |
| How did you hear about us: | | Primary Pharmacy & Location | | | |

Patient's Insurance Information

| <u>Primary Insurance Company Information:</u> | <u>Secondary Insurance Company Information:</u> |
|---|---|
| Policy Holder Information | Policy Holder Information |
| First Name: _____ Last Name: _____ Policy Holders SS#: _____ - _____ - _____ Employer: _____ Patient's Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female Policy Holders Date of Birth: _____ Policy Holder's Address (if different from Patient's) _____ City: _____ State: _____ Zip: _____ Insurance's Name: _____ Policy ID: _____ Group#: _____ Address: _____ Do you have a Co-pay? <input type="checkbox"/> Yes Amt \$ _____ or <input type="checkbox"/> NO | First Name: _____ Last Name: _____ Policy Holders SS#: _____ - _____ - _____ Policy Holders Date of Birth: _____ Patient's Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Policy Holder's Address (if different from Patient's) _____ City: _____ State: _____ Zip: _____ Insurance's Name: _____ Policy ID: _____ Group#: _____ Address: _____ Do you have a Co-pay? <input type="checkbox"/> Yes Amt \$ _____ or <input type="checkbox"/> NO |
| Referral Required: YES NO | Referral Required: YES NO |

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

Patient and/or Guardian Signature: _____ **Date:** _____