

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

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   BELLEVUE    V STREET    GOLD CIRCLE    N 72<sup>nd</sup> STREET

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

<b>Patient's Social Security#</b>			
<b>Patient's First Name:</b>		<b>Patient's Last Name:</b>	
<b>Middle Initial:</b>		<b>Patient's Date of Birth:</b>	/  /
<b>Gender:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
<b>Mailing Address:</b>		<b>City/State/Zip</b>	
<b>Home Phone:</b>	(    )	<b>Emergency Contact:</b>	
<b>Work Phone:</b>	(    )	<b>Relationship:</b>	
<b>Cell Phone:</b>	(    )	<b>Emergency Telephone#:</b>	
<b>Employer:</b>		<b>Primary Physician &amp; Location:</b>	
<b>Reason for today's Visit:</b>		<b>How did you hear about us:</b>	

**Patient's Insurance Information**

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