Foot & Ankle Specialists of NM

PATIENT INFORMATION SHEET

First Name_______________________________ MI______ Last__________________________________

Social Security #_________________ Date of Birth ____/____/____Email address: __________________

**** Primary Care Dr.** ________________________ **** Date Last Seen by Primary Care** ________________

Gender: M/F Ethnicity_____________ Marital Status Div/M/S/Wid

Mailing Address:______________________________ City ________________________ State_____ Zip ______

Home Phone# (   ) ________________ Cell Phone# (   ) __________________

Work Phone# (   ) ________________ Best Way to Reach You: _________________________________

Employer____ Phone# (   )__________________________

Emergency Contact: _______________________________________ Phone#________________________

Pharmacy Name____ Phone#________________________

How did you learn about our office? Referral from: Physician's name/Friend/Yellowpages/internet)

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---Patient's Insurance Information----------------------------------

Primary Insurance Company Information

Company Name__________________________

Address________________________________

Insurance_______________________________

Group#_________________________________

Effective Date___________________________

Do you have a Specialist Copay? Yes Amt$ ____ No

Policy Holder's Name______________________

Policy Holder's SS#_______________________

Policy Holder's Date of Birth_______________

Secondary Insurance Company Information

Company_____________________________

Address______________________________

Insurance_____________________________

Group#_______________________________

Effective Date_________________________

Do you have a Specialist Copay? Yes Amt$___ No

Policy Holder's Name_____________________

Policy Holder's SS#______________________

Policy Holder's Date of Birth______________

* *Do you authorize Foot & Ankle Specialists of NM to email you special offers, promotions, educational materials, or exclusive content? Yes No*

HIPAA DISCLOSURE/AUTHORIZATION TO RELEASE INFORMATION: My signature below denotes my acceptance of podiatric medical care. I authorize release of information to my referring physician or other providers as a necessary part of the course of medical diagnosis and treatment. Authorization is also given to release information to insurance companies necessary to the completion of insurance claims, review of services or receipt of benefits.

Today's Date: ______________________ Patient's Signature __________________________