Foot and Ankle Institute

Established Patient Update

Name:_____

Chart#_____

Name: Last_____ First_____ MI_____

DOB:_____ SSN:_____ Sex: Male / Female

Home #_____ Cell #_____ Consent to text: Yes / No

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Email Address:_____

If Minor: Guardian Name: Last_____ First_____ MI_____

DOB:_____ SSN:_____ Phone #_____

Address:_____

Responsible Party: Responsible Party Is (*Circle one):* *Self* *Parent* *Other*

If the responsible party is not self please provide the responsible parties information.

Name: Last_____ First_____ MI_____

DOB:_____ SSN:_____ Relationship to Patient:_____

Phone #_____ Phone #_____

Address:_____

Emergency Contact: Name_____ Relationship:_____

Phone #_____ Phone #_____

Insurance Information: *Please give current insurance cards to the receptionist to be copied.*

Medical Information:

Drug Allergies: Yes or No

If YES please list:_____

_____

Current Medications:_____

_____

Primary Care Physician (First and Last Name):_____

Local Pharmacy:_____

Foot and Ankle Institute requires that notification be given within 24 hours of your appointment for any cancellations. There is a $50.00 fee for any late cancellations/Missed/No Show appointments.

Patient's Signature:_____ Date:_____

Patient Name Printed:_____

Guardian Signature:_____ Date:_____

Guardian Name Printed:_____ Relationship to Patient:_____