PATIENT INFORMATION (PLEASE PRINT) ANKLE & FOOT CLINIC'S NORTH WEST

Patient Name: (Last) _____(First) _____ (Middle Initial) _____

Address: (Street) _____ (City) _____ (State) _____(Zip) _____

Email_____

DOB: _____ (Age) _____ Sex: M___ F___ Preferred Language: _____

Single___ Married___ Widowed__ Divorced__ Legally Separated___ Significant Other__

Race: _____ **DECLINED**____ Ethnicity: _____ **DECLINED**____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employed: Yes___ No___ Retired___ Full or Part Time: _____ Occupation: _____ Employer: _____

Student: Yes___ No__ Full or Part Time: _____ Primary Care Doctor: _____
Phone: _____
Clinic Name: _____
Referred by:_____

IF WORKERS COMP OR OTHER INSURANCE (PLEASE PRINT)

Treatment Authorized by: Claims Mgr.:___***NEW CLAIM***___ **Re-Open** Claim__ Other__ CLAIM NUMBER_____

Date of Injury: _____ PLACE: Home__ Work__ School__ Auto__ Other__ State Insured: ___ or Self Insured: ___ Motor Vehicle: Yes__ No__

Claims Manager Name: _____ Phone: _____

PRIMARY INSURANCE INFORMATION (PLEASE PRINT)

Insurance Company: _____ Is this PLAN: Group____ Individual___ Self Insured__ or Other___?

Subscribers Name: Last_____ First_____ M. I. ___

DOB: _____ Relation to Patient: Self____ Spouse___ Parent___ Other___ Employer _____

ID/ Policy Number: _____ Grp Number: _____

SECONDARY INSURANCE INFORMATION (PLEASE PRINT)

Insurance Company: _____, Is this PLAN: Group____ Individual___ Self Insured__ or Other___?

Subscribers Name: Last_____ First_____ M. I. ___

DOB:_____ Relation to Patient Self__Spouse__Parent__Other_____Employer:_____

ID/ Policy Number: _____ Grp Number: _____

EMERGENCY CONTACT: Name_____ Relation_____

Phone_____

I understand that the above information must be *complete*, *correct*, and *current* in order for my services to be billed to my insurance. I, the undersigned, authorize payment of medical benefits, both private and Medicare, to Ankle & Foot Clinic's Northwest for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my Insurance. I also authorize you to release to my insurance company, their agent, or CMS, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits. I assign and transfer my rights to Ankle & Foot Clinic's Northwest to act as my representative in obtaining benefit information.

Patient Signature_____ **Date**: _____

PARENT OR GUARDIAN IF UNDER 18