UNIVERSITY FOOT AND ANKLE SPECIALISTS, INC.

Tel: (619) 269-4747 ● Fax: (619) 521-2025

PATIENT INFORMATION *(PLEASE COMPLETE THE ENTIRE FORM)*

PATIENT'S NAME _____ ____ TODAY'S DATE ____/_____/_____

ADDRESS __ ____ CELL (_____) ________________

CITY _ ____________________ STATE ____________ ZIP_ __________ HOME (_____) ________________

DATE OF BIRTH _____/_____/_______ SSN # _______-_______-________ OCCUPATION _________________

E-MAIL ____

MARITAL STATUS: ❒ Single ❒ Married ❒ Divorced/Separated ❒ Widowed AGE _________ SEX: ❒ M ❒ F

EMPLOYER NAME ____ PHONE (_____) _______________

ADDRESS ____

EMERGENCY/SPOUSE____________________________ SSN # ______-_____________ PHONE (_____) _______________

INSURANCE INFORMATION

PRIMARY INSURANCE __________________________ ADDRESS____

____

POLICY# GROUP# GROUP NAME CERTIFICATE# PHONE#

SECONDARY INSURANCE ________________________ ADDRESS____

____

POLICY# GROUP# GROUP NAME CERTIFICATE# PHONE#

HAS YOUR DEDUCTIBLE BEEN MET? ❒ Y ❒ N

AUTHORIZATION AND RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PRACTITIONERS.

I AUTHORIZE THAT UNIVERSITY FOOT AND ANKLE SPECIALISTS, INC. ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT OF MY INSURANCE AND/OR MEDICAL BENEFITS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY AND/OR GOVERNMENT BENEFITS TO PAY DIRECTLY TO THE DOCTOR OR DOCTOR'S GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDANTS.

I HEREBY GIVE MY PERMISSION TO UNIVERISITY FOOT AND ANKLE SPECIALISTS, INC. TO ADMINISTER AND TREAT WITH SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT AND/OR ANKLE CONDITION.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE, WORKERS' COMPENSATION, OR THIRD PARTY PAYER.

I FUTHER AGREE THAT A PHOTOCOPY/FACSIMILE OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

SIGNATURE ____ DATE______________