UNIVERSITY FOOT AND ANKLE SPECIALISTS, INC.

Tel: (619) 269-4747 • Fax: (619) 269-4949

PATIENT INFORMATION (*PLEASE COMPLETE THE ENTIRE FORM)*

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

ADDRESS _____ CELL (_____) _____

CITY _____ STATE _____ ZIP_____ HOME (_____) _____

DATE OF BIRTH _____/_____/_____ SSN # _____-_____-_____ OCCUPATION _____

ETHNICITY _____ RACE_____ 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 _____

SECONDARY INSURANCE _____

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

SIGNATURE _____ DATE_____