FOOT AND ANKLE CENTERS OF OHIO

- **PATIENT INFORMATION**

Name:_____
Address:_____
City:_____State:_____Zip:_____
Social Security Number:_____
Age:_____Date of Birth:_____
Home Phone:_____Work Phone_____
Cell Phone: _____Email_____
Place of Employment:_____
Address:_____
City:_____State:_____Zip:_____
Occupation:_____
Family Physician:_____
Gender: M F Marital Status: _____
Race_____Language _____
Ethnicity: Hispanic/Latino Non Hispanic/Latino
Refuse to report

- **EMERGENCY CONTACT**

Name_____
Address:_____
City:_____State:_____Zip:_____
Relationship:_____Home Phone:_____
Place of Employment:_____
Work Phone:_____ Cell Phone:_____

IF THE PATIENT IS UNDER 18 YEARS OLD PLEASE COMPLETE THE FOLLOWING INFORMATION!

- **FATHER'S INFORMATION**

Name:_____
Address:_____
City:_____State:_____Zip:_____
Home Phone:_____
Business Phone:_____
Date of Birth:_____SS#:_____
Employer:_____
Employer's Address:_____
City:_____State:_____Zip:_____

- **MOTHER'S INFORMATION**

Name:_____
Address:_____
City:_____State:_____Zip:_____
Home Phone:_____
Business Phone:_____
Date of Birth:_____SS#:_____
Employer:_____
Employer's Address:_____
City:_____State:_____Zip:_____

How did you hear about us?

Doctor referral_____

Newspaper Phone Book Google Friend/Relative

Website Business Card Past Patient Facebook

ATTENTION: Please complete ALL of the questions on this form. If it does not apply to you please write N/A so we know that it does not apply to you. If you have questions, please ask the receptionist. Also, if you have any changes in medications or your medical history please inform a clinical employee.

- **WORKERS COMPENSATION**

Is this a work related injury?:_____
Will you be filing this with Workers Compensation?_____
Date of Injury:_____Claim Number:_____
Employer's Name and Address:_____
_____

- **PRIMARY (FIRST) INSURANCE** (still complete if you are filing worker's compensation)

Name of Insurance:_____
Address:_____
City:_____State:_____Zip:_____
Policy Holders Name:_____
Policy Holders Home Address:_____
Policy Holders Date of Birth:_____
Policy Holders Work Phone:_____
ID/SS#:_____

- **SECONDARY INSURANCE**

Name of Insurance:_____
Address:_____
City:_____State:_____Zip:_____
Policy Holders Name:_____
Policy Holders Home Address:_____
Policy Holders Date of Birth:_____
Policy Holders Work Phone:_____
ID/SS#:_____

- **THIRD INSURANCE**

Name of Insurance:_____
Address:_____
City:_____State:_____Zip:_____
Policy Holders Name:_____
Policy Holders Home Address:_____
Policy Holders Date of Birth:_____
Policy Holders Work Phone:_____
ID/SS#:_____

All professional services rendered are charged to the patient. The patient is responsible for fees regardless of insurance coverage or litigation. It is customary to pay for the services when rendered unless other arrangements have been made in advance. If we are a participating provider with your insurance company you are expected to pay your co-pay at time of service.

I hearby authorize FOOT AND ANKLE CENTERS OF OHIO to furnish information to your insurance carrier concerning my illness and treatments and I hearby assign to the physician (s) all payments for my medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature:_____
Date:_____