

Welcome To Our Office
(PLEASE PRINT AND FILL OUT COMPLETELY)

Today's Date _____

Patient's Name _____ **Date of Birth** _____

How would you like our staff to address you/Nickname? _____ Male _____ Female _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone: (____) _____ E-mail _____ **Preferred method of contact:** Phone Email Letter

Social Security # _____ - _____ - _____ **Patient Status: (Please Circle)** Single Married Widowed Divorced Separated

Race: (Please Circle) American Indian/Alaska Native Asian or Pacific Islander Black or African American Caucasian

Chinese Filipino Hispanic Japanese Multiracial Native Hawaiian or Other Pacific Islander Other/undetermined

Ethnicity: (Please Circle) Hispanic or Latino Not Hispanic or Latino Other or Undetermined

Preferred Language: (Please Circle) English Spanish Other: _____

Employer _____ Occupation _____

Phone #(____) _____ Length of Employment _____ Address _____

• **Emergency Contact** _____ Relationship _____

Home Phone(____) _____ Work Phone(____) _____

Name Of Spouse _____ Birthdate _____ Soc.Security # _____ - _____ - _____

Occupation _____ Employer _____ Length of Employment _____

Employer's Address _____ City _____ State _____ Zip _____

Complete This Section if patient is a minor or someone else is financially responsible.

Responsible Party _____ Relationship to Patient _____ Soc.Security# _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone (____) _____ Work Phone (____) _____

Occupation _____ Employer _____ Length of Employment _____

Employer's Address _____ City _____ State _____ Zip _____

How did you hear about our office?

Previous Patient (Name) _____ Friend (Name) _____

Yellow Pages 2nd Opinion Advertisement Hospital Family Newspaper Other

Dr. Referral (Name) _____

Primary Care Physician: _____ Phone # _____ Date Last Seen _____

Preferred Pharmacy: _____ Location _____

Please Describe The Problem You Are Having With Your Foot Or Ankle:

Insurance Information

Primary Insurance Company _____

Secondary Insurance Company (If Applicable) _____

Workers Compensation Claims

Patient's Name _____ Date of Accident _____

Employer (at time of accident) _____ Employer's Phone#() _____ Claim# _____

Name and Address of Insurance Carrier: _____

Adjuster's Name _____ Phone#() _____

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize FOOT AND ANKLE CENTER OF NORTHERN COLORADO to use and/or disclose all medical protected health information (PHI) and billing information about me to or for the party or parties listed below.

Name

Relationship

When my information is used or disclosed following this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that FOOT AND ANKLE CENTER OF NORTHERN COLORADO has acted in reliance upon this authorization. My written revocation must be submitted to FOOT AND ANKLE CENTER OF NORTHERN COLORADO'S PRIVACY OFFICER at 1931 65th Avenue, Suite A, Greeley, CO 80634.

Our office will file all insurance claims for medical charges, including surgical charges. Self-Pay office visits, and non-covered services require payment on the date of service. Please remember, you are responsible for all fees, regardless of insurance coverage & all medical charges if a referral for HMO plans is not obtained prior to date of service.

I authorize the release of any medical information to process insurance claims.

I authorize payment directly to Foot & Ankle Center for the medical and/or surgical benefits, if any, otherwise payable to me for the services as described, realizing that I am responsible to pay for non-covered services.

I've reviewed, understand and consent to the Financial Policies of the Foot & Ankle Center.

Signature of Patient or Legal Guardian _____ Date _____