PROFESSIONAL
Foot & Ankle Centers
DAVISON • LAPEER

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PATIENT INFORMATION FORM

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

Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D S.S.# _____

Address: _____
(Street) (City) (State) (Zip + 4)

Phone: _____ Cell: _____ E-Mail: _____

Primary Care Physician: _____ Date of Last Visit: _____

Spouses Name: _____ Date of Birth: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Required by Medicare *Ethnicity:* ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Hawaiian or Pacific Islander

Primary Insurance: _____ I.D. # _____

Policy Holders Name: _____ Date of Birth: _____

Policy Holders SS#: _____ Relationship to Patient: _____

Secondary Insurance: _____ I.D. # _____

Policy Holders Name: _____ Date of Birth: _____

Policy Holders SS#: _____ Relationship to Patient: _____

Is this Worker's Comp? ☐ Y ☐ N **Auto Accident?** ☐ Y ☐ N **Other Acciddent?** ☐ Y ☐ N

Complete this Section if Patient is a Minor

Responsible Party: _____ Relationship to Patient: _____

Date of Birth: _____ SS#: _____

Address: _____

I attest that the information provided on this form is complete and accurate to the best of my knowledge. I hereby authorize Professional Foot & Ankle Centers, P.C. to furnish any medical information necessary to process insurance claims for my treatment acquired in the course of the examination or hospitalization. I authorize payment of medical and/or surgical benefits to Professional Foot & Ankle Centers, P.C. I understand that the provider's charge may exceed the insurance allowed amount and payment. I will be responsible for any and all balances such as co-insurance, co-payments, and deductibles.

_____ _____
Signature of Patient/Legal Guardian *Date*

_____
Print Name