PATIENT INTAKE FORM

Foot&Ankle CONCEPTS, INC. YOUR FEET ARE IN GOOD HANDS

Welcome and thank you for choosing Foot & Ankle Concepts for you podiatric/foot care needs. In our continuing effort to provide personalized patient care in the most efficient and economical manner possible, we ask that you take a few moments to read our financial policy **(full Financial Policy is posted in our lobby)** and fill out our medical history forms. Your clear understanding of our financial policy is important to our professional relationship.

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____

City / State / Zip: _____

Cell #: ( ) _____ Work #: ( ) _____ Home #: ( ) _____

Birth Date: _____ Sex: M. F. Other Email: _____

Preferred Language: ○English ○Spanish ○ Other: _____ Marital Status: ○S ○M ○D ○W ○ Other

Spouse's / Partner's Name: _____ Phone#: _____

Emergency Contact, Name: _____ Relationship: _____ Phone#: _____

Occupation: _____ Employer: _____

Is this visit a work-related injury? ○Y ○N Workcomp Carrier & Claim #: _____

Whom May We Thank for Referring You? _____

RESPONSIBLE PARTY/INSURANCE

Ins. SubscriberName? _____ Subscriber's DOB: _____ Relationship to Patient: _____

Primary Ins. Co.: _____ ID#: _____ Secondary Ins. Co.: _____ ID# _____

**A copy of your primary and secondary insurance cards must be provided at the time of service. Please note, our office does not bill tertiary insurances. It is the patient's/subscriber's responsibility to ensure that Foot & Ankle Concepts receives the most current active insurance information. Please notify our staff if your insurance information has changed. **

Assignment & Release (Initial one box)

☐ The undersigned, certify that I (or my dependent) have insurance coverage with the above-stated insurance company and assign directly to the treating doctor all insurance benefits, if any, otherwise billable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, including Medicare & Medi-Cal.

☐ I do not have medical insurance or do not wish for my insurance to be billed. I understand that all payments for service is due at the time of service (See Financial Policy for Details!)

Responsible Party Signature: _____ Date: _____ Printed Name: _____