

**FOOT & ANKLE PHYSICIANS, P.A.**  
**WELCOME TO OUR PRACTICE**

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Lot \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male  Female  Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Name of the person responsible for this account \_\_\_\_\_

Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Driver License # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Relation to patient \_\_\_\_\_

**IMPORTANT**

We are happy to file claims with your insurance company(s), on your behalf, for any services provided in our offices. However, it is *your* responsibility to know your insurance plan(s). Most insurance companies require you to pay a deductible and/or a co-payment for your services. We rely on you to know your own plan and share that information with us. Since we may not know your total financial responsibility at the time of your visit, you may get a bill from us after we file with and receive notice from your insurance company(s). The patient and /or responsible party agree to pay all collection, attorney and court fees that may be incurred for the collection of delinquent accounts. *Ultimately, the patient is solely, financially responsible for his or her own account.*

I have read, understand, and accept the above statement \_\_\_\_\_  
Signature of patient or responsible party

Primary Insurance Name \_\_\_\_\_ PPO  HMO  OTHER  \_\_\_\_\_

Do you have a deductible? \_\_\_\_\_ Amount \_\_\_\_\_ A Co-payment? \_\_\_\_\_ Amount \_\_\_\_\_

Name of your medical doctor \_\_\_\_\_ Phone \_\_\_\_\_