Patient Information

Patient Name_____
First Middle Last

Soc.Sec.#_____ Date of Birth_____ -_____ -_____ Gender: Male Female

Address_____City_____State_____ZIP_____

Home Phone#_____ Work#_____ Cell#_____

Email_____ Occupation_____

Marital Status (circle) Married Single Divorced Widowed Other_____

Race_____ Ethnicity_____ Language_____

Who Referred you to our office?_____

Employer_____Primary Care Physician_____

Your Pharmacy_____Street_____Phone_____

Emergency Contact_____Relationship_____Phone_____

Responsible Party_____Phone_____

Responsible Party Address_____

Primary Insurance Policy Holder_____Date of Birth_____

Secondary Insurance Policy Holder_____Date of Birth_____

HIPAA Acknowledgment: I hereby acknowledge that I have been made aware that Family Foot & Ankle Center (FFAC) has a privacy policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and has made this policy available to me. I am entitled to a copy of the privacy policy upon request.

Please answer the following questions by marking YES or NO:
-Is it OK to leave detailed messages on your home or cell voicemail? YES_____ NO_____
-Is it OK to leave detailed messages on your work voicemail? YES_____ NO_____
-Is it OK to leave detailed messages with anyone other than yourself? YES_____ NO_____
(Examples would include, but are not limited to, spouse, domestic partner, adult children, and parents).
Print name of individual(s)_____

I authorize the release of any previous exams, results or images in the event FFAC is in need of them to help with the diagnosis or treatment of my conditions. I permit a copy of the authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. FFAC will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

I authorize FFAC (Dr. Douglas C. Smith or Dr. Patrick J. Dougherty, or whomever they designate) to examine, administer treatment and to perform such general procedures as he (they) may deem necessary in the diagnosis and/or treatment of my condition(s). I further certify that to the best of my belief and knowledge the information provided on my personal health history is true, accurate and complete. I also authorize the physician designated to release information acquired in the course of my examination and treatment.

Signature **X**_____ Date_____

Printed Name of Patient or Guardian_____