Patient Information

First Name_______________________________________ **MI**_____ **Last Name**____

Soc. Sec. # ________-_________-________ **Date of Birth** ________________________________ **Gender: Male Female**

Address____**City**__________________**State**________ **ZIP**_____________

Home #__________________ **Cell#**__________________ **Work #**____________________ (please mark box of preferred #)

Email _________________________________**Marital Status** (circle) **Married Single Divorced Widowed Other**_________

Occupation____ **Employer**____

Race ___________________________ **Ethnicity** ____________________________ **Language**___________________________

How did you hear about our practice?(circle) **Web Search /Referral from MD/Patient /Ins. Co. List/Other**__________

Primary MD ______________________ **Pharmacy**_______________________ **Street**__________________ **Phone**_________

Emergency Contact____________________________________ **Relationship**____________ **Phone**____________________

Responsible Party (for billing purposes) **Name**____________________________________ **Phone**________________________

Address____ _________(if different than above)

Primary Policy - Insured's Name (if other than self) _____________________________ **Date of Birth**________________

Secondary Policy – Insured's Name (if other than self) ___________________________ **Date of Birth**_______________

HIPAA Acknowledgment : I hereby acknowledge that I have been made aware that Family Foot and 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 a 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 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 it 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 Parent or Guardian____