

# Advanced Foot & Ankle Care

Dr. Polansky

Dr. Jones

Dr. Swan

Welcome to our Practice

## Patient Information / This Information is Confidential

Name \_\_\_\_\_

Address \_\_\_\_\_

Street

Apt./Lot#

City / State / Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Cell Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security# \_\_\_\_\_

Parent(s) (if patient is minor) \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Business Phone \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Married \_\_\_\_\_

(spouse's name)

Single  Widowed  Divorced  Separated

Driver's License # \_\_\_\_\_

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

(Name)

(Phone #)

(Relationship)

Name of Pharmacy \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_

Former Podiatrist

Name

Address

Phone Number

Last Visit

Primary Care Physician

Name

Address

Phone number

Last Visit

Cardiologist / Vascular:

Name

Address

Phone number

Last Visit

Physician Managing Diabetes:

Name

Address

Phone number

Last Visit

**Co-Pays:** Co-payments required by an insurance company must be paid at the time of service.

Because this is an insurance requirement, we cannot bill you for these.

**Missed Appointment Fee:** Patients who do not keep their appointment, or cancel with less than

24 hours notice may be charged a \$15.00 fee. Patients with Medicaid as their Primary or Secondary Insurance, who do not keep their appointments or cancel with less than a 24 hour notice, will be dismissed from the practice after their third missed appointment.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Primary Insurance Company

Insurance Company \_\_\_\_\_

I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Date of Birth \_\_\_\_\_

Secondary Insurance  or Medicare Supplement

Insurance Company \_\_\_\_\_

I.D.# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Date of Birth \_\_\_\_\_

2nd Surgical Opinion Required:  Yes  No

Tertiary Insurance  Other Insurance

Insurance Company \_\_\_\_\_

I.D.# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Date of Birth \_\_\_\_\_

Referred By:  Doctor \_\_\_\_\_

Patient \_\_\_\_\_

Family Member \_\_\_\_\_

Saw Sign / Building  Word of Mouth

Newspaper

Yellow Pages:  AT&T  Insurance  Website

Embarq  Yellow Book  Local Pages