PATIENT INFORMATION

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.

Thank you for choosing Highpoint Foot & Ankle Center. In order to serve you promptly, we need the following information. Please type or print. All information will be confidential.

Date: ____________ Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

Patient Name: ______________________________ Email Address: _______________________________________

SSN: ____ Birthdate: ____________ Male Female

Address: _____________________________________ City: ________________ State: ____ Zip: ______________

Marital Status: Married Single Divorced Widowed

Primary Care Physician: ____________________________________

Address: _____________________________________ City: ______________ State: ____ Zip: ______________

Phone Number:______________ Date of Last Visit: ____________

Referred By: ____________________________ Pharmacy Name: ______________ Pharmacy Phone: ___________

RESPONSIBLE PARTY

Name of person reponsible for patient (if other than youself): ____________________________________

Relationship to Patient: ____________________________________

INSURANCE INFORMATION

Name of Insured: ____________________________________

Birthdate: _________________ SSN: _________________ Relationship to patient: ____________________

Name of Employer: ____________________________________ ID#: ____________________________________

Insurance Company: ____________________________________ Group#: _________________________________

Insurance Company Address: ____________________________________

City: ______________ State: ____ Zip: ______________

Do you have additional insurance? Yes No

Name of Insured: ____________________________________

Birthdate: _________________ SSN: _________________ Relationship to Patient: ____________________

Name of Employer: ____________________________________ ID#: ____________________________________

Insurance Company: ____________________________________ Group#: _________________________________

Insurance Company Address: ____________________________________

City: ______________ State: ____ Zip: ______________

AUTHORIZATION & RELEASE

I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

X______________________________________ Date: __________________________________

Signature of Patient (or parent, if minor)