

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: _____

RESPONSIBLE PARTY

Name of person responsible for patient (if other than yourself): _____

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)

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