

# IDAHO FOOT & ANKLE ASSOCIATES

## PATIENT INFORMATION

Date \_\_\_\_\_

**Patient's Name** \_\_\_\_\_

Last

First

Middle

Address \_\_\_\_\_

Street

City

State

Zip

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Social Security # \_\_\_\_\_

Gender: ( M / F ) Marital Status: ( Single / Married / Divorced / Widowed )

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

*Who to contact in an emergency:*

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone # \_\_\_\_\_

**If the patient is a minor, please complete this section:**

**Parent/Guarantor Name** \_\_\_\_\_

Last

First

Middle

Address \_\_\_\_\_

Street

City

State

Zip

Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**How did you hear of our clinic?** Physician / yellow pages / website / radio / insurance / friend

**Primary Care Physician** \_\_\_\_\_ Phone \_\_\_\_\_

**Referring Physician** \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

Patient's relationship to the policyholder: Self / Spouse / Dependent

**Secondary Insurance Company** \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

Patient's relationship to the policyholder: Self / Spouse / Dependent

### All Patients, Please Read & Sign:

I authorize payment of medical benefits from Medicare, Medigap, private and/or group insurance be made on my behalf to Idaho Foot & Ankle for any services or supplies furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration or my insurance company any information needed to determine benefits for related services. I also take responsibility for payment of charges, regardless of payment or denial of payment from my insurance company.

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date