FACAROS FOOT & ANKLE

Patient Information Sheet

Patient's Name:_____ **Date of Birth**:_____
First Name MI Last Name

SS #: _____ ☐ Male ☐ Female **Status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Street Address :_____

City/State/Zip Code:_____ **Home Phone w/Area Code:**_____

Email::_____ **Cell Phone w/Area Code**:_____

Patient's Employer:_____ **Work Phone w/Area Code:**_____

Spouse's Name:_____

Spouse's Employer:_____ **Spouse's best phone #:**_____

Responsible Party:_____ **Relationship:** ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

***If patient is a Minor,** are parents ☐ Married ☐ Divorced **Guardian Parent**:_____

Guardian Address:_____ **Best phone # w/Area Code:**_____

Guardian SS #:_____ **Date of Birth:**_____

Emergency contact:_____

Phone Number w/Area Code:_____ **Relationship to Patient:**_____

Primary Care Physician:_____

Address:_____ **Office #:**_____

Date Last Seen:_____

Referring Physician's Name & Phone Number:_____

Is this Work-related/ MVA /PI (circle one) ? ☐ Yes ☐ No **If yes, exact date of injury(MM/DD/YYYY)?**_____

Claim **#:**_____ Adjuster name/PH#_____ Attorney Name/PH#:_____

How did this injury happen?_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ **Phone Number:**_____

Primary Subscriber's Name:_____ **Date of Birth:**_____

Address:_____

Policy #:_____ **Group #:**_____ **Relationship:**_____

Insurance Company # 2:_____ **Phone Number:**_____

Primary Subscriber's Name:_____ **Date of Birth:**_____

Address:_____

Policy #:_____ **Group #:**_____ **Relationship:**_____

**** IF A REFERRAL IS NEEDED, IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN AND PRESENT AT THE TIME OF SERVICE**

- **I hereby authorize the payment of medical benefits to Facaros Foot & Ankle for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.**
- **I hereby authorize Facaros Foot and Ankle to release any medical information necessary to complete and process my insurance claims.**

_____ _____

Patient or Insured's Signature (If patient is a Minor, must have Responsible Party Signature) Date