Elkhalil Foot And Ankle Specialist

PATIENT INFORMATION **DATE** _____

LEGAL NAME: (Last) _____, **(First)** _____ **(Middle initial)** _____

STREET ADDRESS _____ **APT#** _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE: _____ **ALTERNATE PHONE:** _____ **OCCUPATION:** _____

SS# : _____ **DATE OF BIRTH:** _____ **SEX: M or F**

MARITAL STATUS: _____ **E-MAIL ADDRESS:** _____

EMERGENCY CONTACT NAME: _____ **Relationship to patient:** _____

Home Phone: _____ **Alternate Phone:** _____

Patient Primary Care Physician: _____ **Address :** _____

Primary Care Physician Phone #: _____ **Referring Physician:**_____

Patient OR Responsible Party – (If patient is a minor, parent or guardian should complete this section below)

Responsible Party Name: (Last) _____, **(First)** _____ **(Middle initial)** ___ _____

Relationship to patient: _____ **Home Phone Number:** _____

E-Mail Address: _____ **SS#:** _____

Street Address _____ **Apt. #** _____

City _____ **State** _____ **Zip** _____

Employer Name: _____ **Work Phone:** _____ **ext.** _____

Employer Address _____ **City** _____ **State** _____ **Zip** _____

METHOD OF PAYMENT: _____Cash _____Check _____Insurance

PRIMARY INSURANCE COMPANY NAME: _____

SECONDARY INSURANCE COMPANY NAME: _____

**FRONT DESK PERSONNEL WILL MAKE A PHOTO COPY OF YOUR INSURANCE CARD **

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information necessary to process my insurance claims. I authorize payment directly to the Physician for any professional services rendered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is one that contract directly with the Physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Signature of Patient (or parent/guardian if a minor) _____ **Date** _____