Patient Information Sheet

Personal Information: (PLEASE PRINT CLEARLY)

Name _____ SS# _____ Birthday _____ Age _____

Address _____ City _____

State _____ Zip Code _____ – _____ Home Phone _____ Cell Phone _____

E-mail Address _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____ Phone _____

Marital Status _____ Sex: ❑ Male ❑ Female

In an emergency contact _____ Relationship _____ Phone _____

Referred By _____ ❑ Physician ❑ Patient ❑ Insurance Company

❑ Hospital ❑ Phone Book ❑ On-Line

Primary Care Physician: _____ Phone: _____

First Name Last Name

Responsible Party: (If patient is a minor)

Name _____ SS# _____ Relationship _____

Address _____ City _____ State _____ Zip _____ Phone _____

Employer _____ Occupation _____

Insurance Information:

We will make a copy of your insurance card for our records. If you do not have your card with you, you will need to provide a copy of your insurance card (front and back) and fax it to us at 303-423-2536 within 24 hours.

We will make a copy of your referral (if required) for our records. If you do not have a referral, please ask the front office staff for additional information before seeing the doctor.

Please provide policy holder's date of birth. _____

Payment Policy

Your insurance is a contract between you and your insurance company. While we cannot guarantee that your insurance company will pay your claim, we will provide information to them if requested and the above data is accurate and complete

If you do not have insurance, then payment is due in full at the time of service.

Insurance Authorization and Assignment

I hereby authorize Rocky Mountain Foot & Ankle Center to furnish information to insurance carriers regarding my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any CO-PAYMENTS, DEDUCTIBLES OR BALANCES not covered by my insurance. I authorize use of this form and all my insurance submissions, and I permit a copy of this authorization to be used in place of the original. By signing this form I am consenting to treatment by the doctor in this office and agree to the terms indicated above.

Acknowledgement of Receipt of Privacy Practices

❑ I have reviewed a copy of Rocky Mountain Foot & Ankle's Notice of Privacy Practices with an effective date of April 14, 2003.

❑ I have opted not to receive a copy of Rocky Mountain Foot & Ankle's Notice of Privacy Practices.

Signature _____ Today's Date _____

_____

Parent's printed name and signature if patient is a minor.