Foot & Ankle Center of Clarksburg
Bryan W. Danhires DPM

Patient Information Sheet

Welcome to our Office...

***Attention*: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.**

Social Security#

First Name: **Last Name:** **Middle Initial:**

Date of Birth: (MM/DD/YYYY) ___/___/___ **Gender:** ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Other

Address: **Apt.#:** **City:** **State:** **Zip:**

Home Phone: (   ) **Work Phone:** (   ) **Cell Phone:** (   )

Emergency Contact: **Emergency Telephone#:** (   )

Employer Name: **Employer's Address / City / State / Zip**

Referring Doctor: **Referring Dr.'s Address / City / State / Zip** **Ref. Dr. NPI #**

Primary Care Physician: **Primary Care Physician's Address / City / State / Zip** **P.C.P. NPI #**

Primary Insurance Company Information:	**Secondary Insurance Company Information:**
Policy Holder First Name:	**Policy First Name:**
Policy Holder Last Name:	**Policy Holder Last Name:**
Policy Holders SS# ___-___-___ **Policy Holders Date of Birth:** ___/___/___	**Policy Holders SS#** ___-___-___ **Policy Holders Date of Birth:** ___/___/___
Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other	**Gender:** ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other
Policy Holder's Address: ☐ **Same as patient**	**Policy Holder's Address:** ☐ **Same as patient**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Insurance's Name:	**Insurance's Name:**
Policy ID: **Group #:**	**Policy ID:** **Group #:**
Claim Submission Address:	**Claim Submission Address:**
Effective Date: ___/___/___	**Effective Date:** ___/___/___
Do you have a Co-pay? ☐ No ☐ Yes, Amt $	**Do you have a Co-pay?** ☐ No ☐ Yes, Amt $
Referral Required: ☐ Yes ☐ No	**Referral Required:** ☐ Yes ☐ No

Responsible Party Information – *Please complete if the responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First): **Responsible Party's SSN:** ___-___-___ **Relationship to Responsible Party:** ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip:

FINANCIAL POLICY

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill that I am responsible.

The Practice accepts personal checks. In the event that a check 'bounces' (i.e., insufficient funds exist to cover the check), a fee of $25 will be applied.

All patients receive a reminder call for upcoming appointments. Failure to appear or call to cancel 24hrs prior to an appointment (no show) will result in a $25 fee.

By signing below, I acknowledge and agree to abide by this policy. I also acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices and I agree to comply with all of its terms.

Today's Date:________ Patient's Signature (or parents if under 18 years of age): ________