Patient Information Form

Ankle & Foot Specialists of Puget Sound, P.S.

Date: _____/_____/_____

Patient Name: _____ [ ] M [ ] F
(Last) (First) (MI)

Date of Birth: _____/_____/_____ Age: _____ Social Security: _____-_____-_____

Address: _____ City: _____ Zip: _____

Primary Phone: (_____)_____ ❑Home ❑Cell ❑Work **Leave Message?** ❑ Yes ❑ No

Secondary: (_____)_____ ❑Home ❑Cell ❑Work **Leave Message?** ❑ Yes ❑ No

Email : _____ Sign me up for the Patient Portal: ❒ Yes ❒ No

❑ **Responsible Party is the Same as Patient**

Responsible Party: _____ [ ] M [ ] F
(Last) (First) (MI)

Date of Birth: _____/_____/_____

Mailing Address: _____ City: _____ Zip: _____

Primary Phone: _(_____)_____ ❑Home ❑Cell ❑Work **Leave Message?** ❑ Yes ❑ No

❒ **Student** ❒ **Retired** ❒**Other** ❒ **Employed at:** _____

Primary Care Doctor: _____**Office Name:** _____

Emergency Contact: _____ **Phone Number**: _____

Primary Insurance:_____ ID#:_____ Grp#_____

Name of Subscriber: _____ Relation to Patient: _____

Subscriber's SSN: _____ DOB: _____ Employer:_____

Secondary Insurance:_____ ID#:_____ Grp#_____

Name of Subscriber: _____ Relation to Patient: _____

Subscriber's SSN: _____ DOB: _____ Employer:_____

Is this visit **Injury Related**? _____ Date of Injury: _____ Work/Auto/Other: _____

Employer at time of injury: _____ Claim #: _____

Claim Manager: _____ Phone Number: _____

I consent for medical treatment and I have verified the insurance listed on this form is accurate. I authorize my insurance benefits be paid directly to the Physician/Facility. I am financially responsible for any patient responsibility. I authorize the Physician/Facility or the Insurance Company to release any information required for this claim to be processed.

Signature: _____ Date: _____

Relationship (if minor): _____