

ADVANCED FOOT CENTER, PLLC

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SSN # \_\_\_\_\_  
(Last) (MI) (First)

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home Phone: \_(\_\_\_\_\_) \_\_\_\_\_ Business Phone: \_(\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Referred By: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Position \_\_\_\_\_

Business Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Insured SSN# \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

***Nearest Relative to Notify in An Emergency***

Name: \_\_\_\_\_ Phone \_(\_\_\_\_\_) \_\_\_\_\_

**AUTHORIZATION OF BENEFITS TO PHYSSICIAN:** I hereby authorize payments directly to the physician for the surgical and/or medical benefits and understand I am responsible for any portions of my bill not covered by my insurance company.

**RELEASE OF INFORMATION: I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCDE CLAIM PURPOSES.** The information authorized for release may include information which may consider a communicable or venereal disease including hepatitis, syphilis, gonorrhea, HIV, and AIDS. I understand all the above and hereby state that the information is correct and to the best of my knowledge

Date \_\_\_\_\_  
\_\_\_\_\_ (signature)