

NORTHWEST FOOT AND ANKLE CENTER, PS

MARK T LEWIS, DPM PETRINA C LEWIS, DPM

PATIENT INFORMATION

NAME: (LAST)_____ (FIRST)_____ (MI)_____

DATE OF BIRTH:_____ AGE:___ SEX: MALE FEMALE SS#_____

ADDRESS:_____

CITY, STATE, ZIP:_____

MARITAL STATUS: S M W D EMAIL ADDRESS:_____

PHONE #: _____ CELL #: _____

EMPLOYER: _____ WORK #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

RESPONSIBLE PARTY: _____	RELATIONSHIP TO PATIENT: _____
SS#: _____	DATE OF BIRTH: _____

INSURANCE INFORMATION

IB WC AA SELF PAY

PRIMARY:

INSURANCE CO: _____ PHONE # _____

SUSCRIBER NAME: _____ DOB: _____

ID # _____ GROUP # _____ SS# _____

SECONDARY:

INSURANCE CO: _____ PHONE# _____

SUSCRIBER NAME: _____ DOB: _____

ID # _____ GROUP # _____ SS# _____

WORKERS COMP/AA:

INSURANCE CO: _____ PHONE # _____

ADDRESS: _____

CITY, STATE, ZIP: _____ CLAIMS MNGR _____

CLAIM #: _____ CLAIM OPEN Y N IF CLOSED DATE _____

WORK RELATED INJURY: YES NO

DATE OF INJURY: _____

AUTO ACCIDENT: YES NO

BODY PART: R/L _____

3RD PARTY ACCIDENT: YES NO

CAUSE: _____

OTHER INJURY: YES NO

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I AUTHORIZE NORTHWEST FOOT AND ANKLE CENTER TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO NORTHWEST FOOT AND ANKLE CENTER. I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO COLLECT ANY PAYMENTS TO ALL INSURANCE COMPANIES I FURTHER AUTHORIZE RELEASE OF MEDICAL INFORMATION TO ANY AND ALL PHYSICIANS INVOLVED IN MY CARE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF ITS ORIGINAL. I AUTHORIZE THE USE OF SIGNATURE ON FILE TO BE USED ON ALL OF MY INSURANCE SUBMISSIONS. I UNDERSTAND THAT I AM RESPONSIBLE FOR NOTIFYING THE OFFICE OF ANY PRECERTIFICATION, REFERRALS, OR CHANGES NEEDED FOR MY INSURANCE.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____