COASTAL CAROLINA FOOT & ANKLE CARE

Date ____________________ Patient # ________________

Name ____ Date of Birth ________________________
FIRST MIDDLE LAST MONTH DAY YEAR

Gender: M F Marital Status: S M W D CH Social Security Number _________-_______-_________

Race: African American Asian Caucasian Hispanic Native American Pacific Islander

Address ____ Telephone # ( ) _______-_______
NUMBER & STREET NAME CITY & STATE ZIP CODE

Mailing Address (If different) ____ Cell Phone# ( ) _______-________

E-mail Address ____

Employer Name ____ Telephone # ( ) _______-________
IF MINOR, PARENT OR GUARDIAN EMPLOYER NAME

If Minor: Parent(s) Name ____ Date of Birth __________________

Social Security Number _________-______-_________

Family Physician: ____ Date of Last Visit: ________________

Pharmacy Name: ____ Phone Number: __________________

PLEASE SUBMIT ALL INSURANCE CARDS

Primary Insurance _______________________ Policy Number ______________________ Group Number __________

Policy Holder ____________________________ Relation ____________ Date of Birth _____________________

Secondary Insurance ______________________ Policy Number ______________________ Group Number __________

Policy Holder ____________________________ Relation ______________ Date of Birth _____________________

**Were you referred to us? Yes or No By whom? ______________________________
** If you have been here before, how long ago? ______

AUTHORIZATION FOR RELEASE OR INFORMATION/PAYMENT OF BENEFITS: I authorize payment directly to Coastal Carolina Foot & Ankle Care for any medical or surgical benefits, otherwise payable to me under the terms and conditions of my contract with the insurance company or other medical facility. Photocopies of authorization to be as valid as the original. I authorize the use of this signature on all insurance submissions.

Receipt of Notice of Privacy Practice: I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the notice.

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to access/review information, administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles.

**PATIENT/GUARDIAN SIGNATURE: ____ DATE: ____________