Elite Foot And Ankle
New Patient Information

Name: ____
Last First Middle

Address: ______________________________ City: ______________________

State: ______________ ZIP: __________ Employer: ______________________

Phone: ________________ Cell: ________________ Work: ________________

Race: African American / Asian / Caucasian / Hispanic / Native American / Other (Circle One)

Ethnicity: Hispanic / Non Hispanic / Refused to Report (Circle One) Preferred Language: ___________________

Primary Care Physician: _________________________ Phone #: ______________ Fax # ___________________

Referring Physician: ____________________________ Phone #: ______________ Fax#: ___________________

Date of Birth: ______________ SS#: ______________________ Married Single
Circle One

Insured's Name: ____
Last First Middle

Insured's Address: ______________________________ City: ______________________

State: ____________ ZIP: __________ Phone: ______________ SS#: ________________
Insured

Insured's Date of Birth: ________________ Relationship to Patient: ______________________

Insurance Company: ____
Primary Secondary

Emergency Contact Name: ________________________ Relationship: ____________________

Phone: ________________________ Work Phone: ____________________ Cell Phone: ___________________

Preferred Pharmacy: ______________________ Address: __________________ Phone: ___________________

Email address: ____

Consent for Medical Care - Permission is hereby granted to the doctors, nurses and employees of Elite Foot And Ankle to do such procedures as may be necessary to diagnose, treat and care for the needs of myself or my dependants for whom this form is completed

____
Signed Date

Billing - I hereby authorize Elite Foot And Ankle to furnish my insurance company, if applicable all information requested regarding my illness or injury. I also understand I am responsible for all outstanding balances deemed appropriate by my insurance company or all balances in the absence of a current policy.

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Signed Date