PERSONAL INFORMATION

Cutting Edge Foot & Ankle

Patient:_____ Home phone:_____

Address:_____ Business phone:_____

City/Town/Zip:_____ Mobile phone:_____

Sex:_____ Age:_____ DOB:_____ Marital status:_____

Email:_____

Primary Language:_____ Race:_____

Occupation:_____

Employed by:_____

MEDICATION:

_____

_____

_____

Referring M.D.:_____ Date last seen:_____

Pharmacy:_____ Phone:_____

PCP Name: _____ Telephone Number:_____

Past Medical History:_____

_____

Reason for todays visit:_____

Description of Symptons:_____

BILLING INFORMATION

Medical Insurance:_____ ID #_____

RESPONSIBLE PARTY for MINOR CHILD

Parent's Name:_____

Address:_____

_____

_____

Phone:_____

WORKMAN'S COMPENSATION

Party to be billed:_____

Address:_____

_____

_____

Claim/File #:_____ Date of Accident:_____

EXTENDED AUTHORIZATION

I hereby authorize Cutting Edge Foot & Ankle Clinic to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Cutting Edge Foot & Ankle Clinic all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for payment if I have not fulfilled their requirements. I also aknowlege the reciept of HIPPA privacy policy.

Signature:_____ Date:_____

CONSENT FOR TREATMENT

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Cutting Edge Foot & Ankle Clinic and/or his designees.

Signature:_____ Date:_____