

PATIENT INFORMATION

Date _____
Patient Name _____ Date of Birth _____ Sex: M F
Marital Status: M S W D Social Security # _____ - _____ - _____
Address _____ City _____
State _____ Zip _____ - _____ Telephone (Home) _____
Place of Employment _____
Business Address _____ Telephone (Work) _____

Spouse/Parent _____ Social Security # _____ - _____ - _____
Address (if different than above) _____
City _____ State _____ Zip _____ - _____ Telephone (Home) _____
Place of Employment _____
Occupation _____ Telephone (Work) _____

Person Who Does Not Live With You To Contact In Emergency
Name _____ Phone # _____ Relationship _____
Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to our office? _____
 Friend/Family Internet Yellow Pages Doctor _____
What type of foot problem are you having? _____ Please Write Name

INSURANCE INFORMATION

(Please present your insurance card(s) to the receptionist)

Medical Insurance Company _____
 HMO PPO TRADITIONAL MEDICARE OTHER _____
Policy Holder / SSN / DOB _____
Secondary Insurance Company _____
Policy Holder / SSN / DOB _____
Responsible Party _____

Financial Agreement

Payment for office visits and laboratory work is due at the time of service unless prior arrangements have been made. To assist you, Arlington/Mansfield Foot & Ankle Centers, P.A. will accept insurance assignment for your surgical care. You are responsible for your deductible and co-insurance amounts.

Payment Preference Cash Check VISA MasterCard American Express Discover

Assignment of Benefits

I authorize payment of medical benefits to Arlington/Mansfield Foot & Ankle Centers, P.A. for services rendered.

Authorization for Treatment

I authorize Drs. Valentine, Landry, Southerland, Warren and/or Rabjohn to treat my condition medically, surgically, and orthopedically.

Signed _____ Date _____