



# CHICAGO FOOT & ANKLE

Podiatric Medicine & Surgery

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## WELCOME TO OUR OFFICE

### PATIENT INFORMATION

Patient Name:			Social Security #:		
Patient's Address:		City:		State:	Zip Code:
Home #:	Cell #:		Work #:		Email:
Date of Birth:	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Minor/Under 18	<input type="checkbox"/> Single
		<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
Employer:			Occupation:		<input type="checkbox"/> Student
Name of Spouse			Name of Parent (if patient is a minor)		
Emergency Contact			Phone #		

### INSURANCE INFORMATION

NO INSURANCE

Name of Primary Insurance	Name of insured (if other than self)		Insured's Date of Birth
Name of Spouse's/Other Insurance	Name of insured (if other than self)		Insured's Date of Birth
Patient is the: <input type="checkbox"/> Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			

### ACCIDENT OR WORK INJURY INFORMATION

NOT A WORK INJURY OR ACCIDENT

Date of Injury	Type of Injury: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other			Has a claim been filed?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Claim #	Contact #			

### PRIMARY CARE DOCTOR AND PHARMACY INFORMATION

Primary Care Doctor	Address		Phone #
Primary Pharmacy	Address		Phone #
Previous Podiatrist	Address		Phone #
How did you learn about our office?			

### WHAT PROBLEMS ARE YOU HAVING WITH YOUR FEET?

\_\_\_\_\_

\_\_\_\_\_

### RELEASE OF BENEFITS INFORMATION

I authorize my insurance benefits to be paid directly to the doctor. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. All co-payments are due on the day of service.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_