Last Name: ______________________ First Name: ______________ Middle Initial: __

Address: ______________________ Address 2: ______________________

City: ____________ State: ___ Zip Code: ______________

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ Email: ______________________________

Date of Birth: ____________ Sex: Female ____ Male____ Other____

Race: White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Patient Declined ☐

ETHNICITY: Not of Spanish/Hispanic Origin ☐ Spanish/Hispanic Origin☐ Decline/Unknown ☐

Language: ______________________

Primary Care Physician (PCP): ______________________________

Date of your most recent visit to your Primary Care Physician: ______________________

Pharmacy Name and Location: ______________________________

HIPAA CONTACT INSTRUCTIONS: Please check all boxes where send appointment and medical information to:

Appointment Information:		**Medical Information:**	
Home Phone	☐	Home Phone	☐
Mobile Phone	☐	Mobile Phone	☐
Mobile Text	☐	Mobile Text	☐
Work Phone	☐	Work Phone	☐
With Another Person	☐	With Another Person	☐
Send via Mail	☐	Send via Mail	☐
Send via E-Mail	☐	Send via E-Mail	☐

In accordance with HIPAA, please specify the person(s) who Advanced Regional Center for Ankle and Foot Care is able to communicate with:

____ Emergency Contact: Yes ☐ No ☐

Name Phone Relationship

____ Emergency Contact: Yes ☐ No ☐

Name Phone Relationship

The notice of privacy practice is posted in our office for your review. A copy shall be provided to you unless you decline. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers and conduct normal health care operations such as quality assessments and accreditation.
I certify that the above information is correct and I request services.

______________________________ ______________

Signature Date

LAST NAME: ____________________________________ First Name: ______________________ Middle Initial: ____

FINANCIAL INFORMATION AND AUTHORIZATION

FINANCIAL TYPE: Auto Injury ☐ Workers Compensation ☐

Claim number: ____

Employer Name: ____

Contact Person: ____

Telephone Number: ____

Date Injury Occurred: ____

....

RESPONSIBLE PARTY (POLICYHOLDER OF INSURANCE)

Policyholder Name: ____ Date of Birth: _______________________

Relationship to Patient: ____ SS#: __________________

Where should your medical statements be mailed to:

Address: ____

City: ____ State: ______ Zip Code: ___________________________

Phone: _______________________________