



Ankle & Foot Centers, PC
Medicine & Surgery of the Foot and Ankle

Mathew M. John, DPM, FACFAS

Patient Name _____ Date of Birth _____ Age _____
 Social Security number: _____ circle: Male/Female Single / Married / Divorced
 Address _____ City _____ ST _____ Zip _____
 Home phone: (_____) _____ - _____ Cell phone: (_____) _____ - _____
 Email address: _____

Place of Employment _____
 Address _____ City _____ ST _____ Zip _____
 Work #: (_____) _____ - _____ Ext _____

Spouse/Responsible Party's Name _____ Date of Birth: _____
 Social Security number: _____ circle: Male/Female Single / Married / Divorced
 Address _____ City _____ ST _____ Zip _____
 Home phone: (_____) _____ - _____ Cell phone: (_____) _____ - _____

Spouse/Responsible Party's Place of Employment _____
 Address _____ City _____ ST _____ Zip _____
 Work# (_____) _____ - _____ Ext _____

Relative or Friend for Emergency Contact

Name _____ Relation _____
 Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
 Work Phone (_____) _____ - _____

How did you hear about our office?

Referral Source: Doctor's full Name _____ Friend/relative _____
 HMO/PPO Directory Yellow Pages internet building/sign employer Northside referral advertisement

Insurance Information – PLEASE PRESENT INSURANCE CARD AND DRIVERS LICENSE OR IDENTIFICATION CARD TO RECEPTIONIST

Primary Insurance _____ HMO PPO POS
 Policy Holder's Name _____ Policy # _____
 Secondary Insurance _____ HMO PPO POS
 Policy Holder's Name(if different from above) _____ Policy # _____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records via fax transmittal or mail, to all referred physicians and to my insurance company when applicable. I authorize and request that insurance payment be made directly to Ankle & Foot Centers, PC, should they elect to receive such payments. I have read and understand the above consent for treatment, release of medical information, insurance authorization and accept financial responsibility for all coinsurance, copays, and deductibles as applicable to my insurance policy. I understand that the cost of collection (30%) will be added to my account in the event it becomes delinquent and sent to a collection agency.

SIGNATURE

DATE

FOR OFFICE USE ONLY

I acknowledge full financial responsibility for services and/or items not covered by my insurance and authorize to Ankle & Foot Centers, PC, all unpaid amounts to my Visa or MasterCard after 90 days from the date of service

Visa/MasterCard # _____ Exp date: _____

Signature Authorizing transfer _____ Date _____