Welcome

Thank you for selecting our Healthcare team! We will strive to provide you with the best possible health care. To help us meet all your Healthcare needs, please fill out this form completely in ink. We will also need your insurance cards and photo ID when finished. If you have any questions please feel free to ask.

Personal Information: **Today's Date:** _____

Patient Name_____ Date of Birth_____

Wishes to be called_____ Soc. Sec.#_____

Address_____

City / State / Zip _____

Sex: Male / Female Marital Status: S M X D W P Spouse Name_____

Race: White / American Indian / Asian / African American / Hispanic / Hawaiian / Prefer not to answer / Unknown

Preferred Language_____ Ethnicity_____

Patient's Employer_____ Occupation_____

Address / City, State, Zip _____

Referred By PCP, Friend, Relative, Website _____

Family Doctor _____ Phone_____

(NO GROUP NAMES)

Pharmacy_____ Location_____

Are you Diabetic: Yes / No, Insulin Dependent: Yes / No, Last seen Family Dr.: _____

Responsible Party: **Who is responsible for payment on account? (if patient leave blank)**

Name _____ Date of Birth_____

Relationship to patient: parent / caregiver / POA / Court Order SS#_____

Address _____

Home Phone_____ Cell _____

Patient's Telephone:

Home _____ Cell _____

Work,Ext.#_____ Email_____

Prefer to receive calls at: Home / Work / Cell Phone Time of day_____

In the event of an emergency, who should we contact **other than your spouse/parent**?

Name_____ Relationship_____ Phone_____

Do you have an Advance Directive? ☐ yes ☐ no, if yes please provide office a copy

Privacy Information Preferences **Can we leave information on your:**

home phone?	☐ appointment info	☐ medical / billing info	☐ **do not** leave msg
cell phone?	☐ appointment info	☐ medical / billing info	☐ **do not** leave msg
work phone?	☐ appointment info	☐ medical / billing info	☐ **do not** leave msg
send via mail?	☐ appointment info	☐ medical / billing info	
send via E-mail?	☐ appointment info	☐ medical / billing info	

Can we send reminders and newsletters via E-mail? yes / no

Who can we leave messages with? _____

Insurance Information: Primary **Additional Insurance**

Insured Employee:_____ Insured Employee: _____

Relationship to patient_____ Relationship to patient _____

D.O.B._____ D.O.B._____

Soc.Sec#_____ Soc.Sec#_____

Employer_____ Employer_____

Insurance Co._____ Insurance Co._____

Policy #_____ Policy #_____

Group#_____ Group#_____

Authorization and Release:

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to the third party payors and/or other health practioners.

I authorize and request my insurance company to pay directly to the doctor or doctor;s group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that by signing this that the above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

I authorize Fleetwood Footcare Center, PC to retrieve my medication history. I also acknowledge that I received my HIPAA Privacy Practice Notice.

X_____

Signature of patient, parent if minor, or Power of Attorney Date