Rassfeld FOOT and ANKLE PC

Patient's Last Name First MI Marital status Spouse's name

Mailing/ Billing Address City, State, Zip Home phone #

Physical Address City, State, Zip Cell phone #

Emergency Contact Name / Phone Number Relation to patient

Race: White Black or African American Hispanic Asian Other_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Primary Language _____

M F
Gender Date of Birth Age Occupation Parent(s)/guardian name(s) if minor

Email address: _____ I would like appointment reminders via email **Yes** **No**

* Required for patient portal access to electronic health record

How did you hear about our clinic? Friend/Family Internet Facebook Insurance Phonebook Shoe store
Drive by Former patient Dr_____ Other_____

Primary Physician: _____ Date last seen by your doctor_____

Pharmacy name and location:_____

Patient's employer (or father's info if patient is minor) Business address Work phone #

Spouse's employer (or mother's info if patient is minor) Business address Work phone #

Medical Insurance

Primary:_____ _____ _____
Name of insurance company Insured's name, address Insured's birth date & SS#

Secondary:_____ _____ _____
Name of insurance company Insured's name, address Insured's birth date & SS#

Tertiary:_____ _____ _____
Name of insurance company Insured's name, address Insured's birth date & SS#

I have had an opportunity to read the practice financial policy and receive a copy if so desired.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Patient or Guardian Signature **Date**