

WELCOME TO MAPLEWOOD PODIATRY member MIDWEST FOOT & ANKLE SPECIALISTS

DATE _____

PATIENT NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE(HOME)(____) _____ WORK(____) _____ CELL(____) _____

Email _____

BIRTHDATE _____ AGE _____ MARITAL STATUS M S D W
NUMBER OF CHILDREN _____

SOCIAL SECURITY # _____ SEX MALE _____ FEMALE _____

IS THIS A WORK RELATED INJURY? YES NO DATE OF INJURY _____

INSURANCE INFORMATION

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____

PLACE OF EMPLOYMENT _____

BUSINESS PHONE (____) _____ SS# OF EMPLOYEE _____

PRIMARY INSURANCE _____

GROUP # _____ INDIVIDUAL # _____

SECONDARY INSURANCE SUBSCRIBERS NAME _____

INSURANCE COMPANY NAME _____

GROUP # _____ INDIVIDUAL # _____

RELEASE AND ASSIGNMENT

It is imperative that you as a patient understand coverage is a contract between you and your insurance carrier. The ultimate responsibility for payment of all charges incurred rest with you the patient or responsible party.

I authorize and request my insurance company to pay directly to **Midwest Foot & Ankle Specialists, LLC**

the amount due to me in my pending claim for basic medical, major medical or surgical treatment, and any services rendered to me as a patient. I also authorize **Midwest Foot & Ankle Specialists, LLC** to release to my insurance company or it's representative any information, including diagnosis and treatment rendered to me during the period of my care. I understand the charge of any non-covered services (such as routine foot care) are my responsibility. This authorization is in effect until I choose to revoke it.

SIGNATURE _____ **DATE** _____

(PARENT OR GUARDIAN PLEASE SIGN IF PATIENT IS A MINOR)