❑ Jeffrey Christensen, DPM, FACFAS ❑ Mary Crawford, DPM, FACFAS ❑ Cherie Johnson DPM, FACFAS ❑ Jarrod Smith, DPM ❑ Robert Stanton, DPM

Appointment date: ________________ Check-in time: ______________ Appointment Time: ______________

Patient Information (Please Print)

Patient's Name: (Last)____(First)__________________________________ (Middle Initial)_______

Address: (Street) ____ (City) ____________________ (State) ____________ (Zip)___________

Social Security Number: ___________________________ **Birth date:** _____/______/_____**Age**_________ **Sex:** M [ ] F [ ]

Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ] Legally Separated [ ] Significant Other [ ]

Email Address:____

Home Phone: (________) ____________________ **Work Phone:** (________) ___________________**Cell Phone:**(_______)________________

Employed: Yes [ ] No [ ] Retired [ ] If Yes, Full Time [ ] Part Time [ ] **Occupation** __________________**Employer** ________________

Student: Yes [ ] No [ ] If Yes, Full Time [ ] Part Time [ ] **Reason For Today's Visit** ____

Primary Care Doctor: ______________________________**Clinic Name:**________________________ **(Date of last visit)**______/______/______

Primary Doctor's Phone (_____) ______________ **Referred By:** (Doctor/Friend/Co-worker's name or Other Entity)__________________________

Person Financially Responsible For This Account (This is the Person Who Signs The Billing And Credit Policy)

Name: (Last)_________________________ (First)___________________ **Relation to Patient:** Self [ ] Spouse [ ] Parent [ ] Other [ ]_______

Address: (Street) ____ (City) __________________ (State) ____________ (Zip)___________

Home Phone: (________) ____________________ **Birth date:**______/_______/______ **Social Security Number:** __________________________

Drivers License: (Number) _____________________________ (State) _______________ **Occupation:** ______________________________

Employer: (Name)____ (Phone) (________) __________________

Insurance Information (Please Print)

Workers Comp: Yes [ ] No [ ] State Insured [ ] or, Self Insured [ ] **Motor Vehicle:** Yes [ ] No [ ] **Date Of Injury:**_____/______/______

Treatment Authorized by: Claims Manager [ ] Other [ ] New Claim [ ] Re-open Claim [ ] **Claim Number:** _____________________________

Claims Manager: (Name)____ (Phone) (________) __________________

Primary Insurance Company/ Subscriber Information (Please Print)

Insurance Company Name______________________________ (Address)_____________________________ (Phone) (____) ______________

Does this insurance require a referral: Yes [ ] No [ ] if Yes **Authorization number**____

Is this plan: Group [ ] Individual [ ] Self Insured [ ] Other [ ] ___________________________ **Effective Date of this plan:**______/______/______

Subscribers Name: (Last)_______________________________________ (First)__________________________________ (Middle Initial)________

Social Security Number: ___________________ **Birth date:**_____/______/_____ **Relation to Patient:** Self [ ] Spouse [ ] Parent [ ] Other [ ]________

ID/Policy Number: ____________________**Group Number:**___________ **Subscriber Employer:** ___________________**Phone(**____**)**___________

Secondary Insurance Company/Subscriber Information (Please Print)

Insurance Company Name______________________________ (Address)___________________________(Phone) (________) __________________

Does this insurance require a referral: Yes [ ] No [ ] if Yes **Authorization number**____

Is this plan: Group [ ] Individual [ ] Self Insured [ ] Other [ ] ___________________________ **Effective Date of this plan:**______/______/______

Subscribers Name: (Last)_______________________________________ (First)__________________________________ (Middle Initial)________

Social Security Number: ___________________ **Birth date:**_____/______/_____ **Relation to Patient:** Self [ ] Spouse [ ] Parent [ ] Other [ ]________

ID/Policy Number: ___________________**Group Number:**__________ _ **Subscriber Employer:** ____________________**Phone(**____**)**___________

Person to contact in case of emergency (Not living with you):

Name: ____________________________________ **Relationship to patient**: ______________________ **Phone:** (________) __________________

Private Insurance Authorization for Assignment of Benefits/Information Release:

I understand that the above information must be *complete*, *correct*, and *current* in order for my services to be billed to my insurance. I, the undersigned, authorize payment of medical benefits, both private and Medicare, to the Ankle & Foot Clinic of Everett for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, their agent, or CMS, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits. I assign and transfer my rights to Ankle & Foot Clinic of Everett to act as my representative in obtaining benefit information.

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Patient Signature (Parent or Guardian Signature If Child Under 18 Years) Date