

Elkhalil Foot And Ankle Specialist

PATIENT INFORMATION

DATE _____

LEGAL NAME: (Last) _____, (First) _____ (Middle initial) _____

STREET ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP _____

PHONE: _____ ALTERNATE PHONE: _____ OCCUPATION: _____

SS# : _____ DATE OF BIRTH: _____ SEX: M or F

MARITAL STATUS: _____ E-MAIL ADDRESS: _____

EMERGENCY CONTACT NAME: _____ Relationship to patient: _____

Home Phone: _____ Alternate Phone: _____

Patient Primary Care Physician: _____ Address : _____

Primary Care Physician Phone #: _____ Referring Physician: _____

Patient OR Responsible Party – (If patient is a minor, parent or guardian should complete this section below)

Responsible Party Name: (Last) _____, (First) _____ (Middle initial) _____

Relationship to patient: _____ Home Phone Number: _____

E-Mail Address: _____ SS#: _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Employer Name: _____ Work Phone: _____ ext. _____

Employer Address _____ City _____ State _____ Zip _____

METHOD OF PAYMENT: _____ Cash _____ Check _____ Insurance

PRIMARY INSURANCE COMPANY NAME: _____

SECONDARY INSURANCE COMPANY NAME: _____

****FRONT DESK PERSONNEL WILL MAKE A PHOTO COPY OF YOUR INSURANCE CARD ****

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information necessary to process my insurance claims. I authorize payment directly to the Physician for any professional services rendered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is one that contract directly with the Physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Signature of Patient (or parent/guardian if a minor) _____ Date _____