VALDOSTA FOOT AND ANKLE CLINIC, P.C.

MICHAEL R. WALLACE, DPM, FACFAS
DEVIN L. DAUGHERTY, DPM, FACFAS

PATIENT INFORMATION

NAME ____ SSN ______________
FIRST MI LAST

ADDRESS ____ DATE OF BIRTH ______________

____ MALE ______ FEMALE ______ AGE ______

HOME PHONE ______________ WORK PHONE ______________ MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed

EMPLOYER ______________________ POSITION ______________ EMPLOYMENT DATE ______________

PRIMARY CARE PHYSICIAN ______________________________ CITY ______________

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ Doctor ______________________ ☐ Sign ☐ Phone Book
☐ Friend ______________ ☐ Other ______________

SPOUSE INFORMATION

SPOUSE'S NAME ____ SSN ______________

EMPLOYER ______________________________ POSITION ______________________

EMPLOYMENT DATE ______________________________________ DATE OF BIRTH ______________

PARENT INFORMATION

IF YOU ARE 18 YEARS OR YOUNGER, OR ARE COVERED ON YOUR PARENT'S INSURANCE POLICY – FILL OUT THE PARENT INFORMATION BELOW.

FATHER'S NAME ______________________ MOTHER'S NAME ______________________

ADDRESS ______________________ ADDRESS ______________________

______________________ ______________________

EMPLOYER ______________________ EMPLOYER ______________________

SSN ______________________ SSN ______________________

DATE OF BIRTH ______________________ DATE OF BIRTH ______________________

INSURANCE INFORMATION

(Please provide insurance cards for copy).

PRIMARY INSURANCE CO. ____

SECONDARY INSURANCE CO. ____

OTHER ____

EMERGENCY INFORMATION

EMERGENCY CONTACT: (List someone who does not live with you – THIS MUST BE FILLED OUT.)

NAME ______________________________ RELATIONSHIP ______________________________

HOME PHONE ______________________________ WORK PHONE ______________________________

ADDRESS ____

ASSIGNMENT AND RELEASE

I certify that the above information is true and correct to the best of my knowledge. I give my permission to **Michael R. Wallace, D.P.M.** and /or **Devin L. Daugherty, D.P.M.** to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my feet.

I certify that I (or my dependent) have insurance coverage and assign directly to **Valdosta Foot and Ankle Clinic, P.C.,** all insurance benefits. I understand that I am financially liable for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

______________________________ ______________________________
Patient Signature (or Responsible Party) Date

MEDICARE AUTHORIZATION (For Medicare Patients Only)

I request payment of authorized Medicare benefits to be made either to me or on my behalf to **Valdosta Foot and Ankle Clinic, P.C.** for any services furnished me by a physician of the clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________________________
Beneficiary Signature Date

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