SMOKY MOUNTAIN FOOT AND ANKLE CLINIC

Date_____________ Referred by________________________________

PATIENT INFORMATION

Last Name ____________________First Name___________________MI ___________

Mailing Address

____________________________City______________State_____Zip______________

Residence Address

____________________________City______________State_____Zip______________

Email address_______________________Phone______________Married?__________

Work Phone_______________________Cell Phone_______________________________

Social Security #________________________Sex____Birthdate___________________

Occupation_________________Employer__________________________________

Employer'sAddress_____________________________________Phone______________

Nearest Relative Not Living With You____

Relative'sAddress______________________________________Phone______________

Emergency Contact____

Relationship to you____________________Contact's Phone________________________

Who Is Responsible For Bill?_______________________Phone#___________________

Address of Responsible Party____

Employer____________________Birthdate_______________________________________

Primary Insurance:

Insurance Company__________________________Policy #______________________

Group #______________________Street Address_______________________________

City__________________State______Zip__________Phone______________________

Secondary Insurance:

Insurance Company__________________________Policy#______________________

Group#_______________________Street Address_______________________________

City____________________State______Zip__________Phone_____________________

Subscriber Name:_________________________________Birthdate_________________

Address____

Employer____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I AUTHORIZE PAYMENT OF BENEFITS TO SMOKY MOUNTAIN FOOT CLINIC, AS AGREED UPON AT THE TIME OF TREATMENT.

Signature____Date_____________