Appalachian Foot and Ankle Associates **Date:_____**
Patient Information Form **ID #: _____**

Patient Last Name _____ First _____ Middle _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Cell _____ Work _____

E-mail Address _____

Date of Birth _____ SSN _____ Sex *M* or *F* Marital Status *(circle) S M W D P*

Race *(circle)* African American American Indian White Asian Other Declined
Ethnicity *(circle)* Hispanic Non-Hispanic **Primary Language _____**

How did you hear about our office or who were you referred by? _____

Employer _____ Occupation _____

Preferred Pharmacy and Address _____

Primary Insurance _____ Secondary Insurance _____

Who carries the Insurance (subscriber)? (circle) Self Child Spouse Partner Other _____

Name Of Subscriber _____ Subscriber DOB _____

Subscriber SSN _____ Subscriber Employer _____

If someone else *(other than the patient or the patient is a minor)* is responsible for the patient bill, please complete:

Responsible Party Name _____ DOB _____

Responsible Party Address _____

Responsible Party Telephone # _____ Responsibility Party SSN _____

Emergency Contact _____Telephone _____ Relationship _____

Please Note: *All Co-pay and un-met deductibles are due at the time of service. It is the patient / guardian's responsibility to know and understand their individual health insurance coverage.*