RAPPAHANNOCK FOOT & ANKLE SPECIALISTS

WELCOME TO OUR OFFICE

Please answer **ALL** questions to the best of your ability. This information is important for your health and our records. If you need more room for any of the questions, you may flip over to the backside to finish

Dr. Mr. Mrs. Ms. Name - Last_____ First_____ MI _____ Suffix _____

Mailing Address (Street, P.O. Box, Apt #) _____

City:_____ State:_____ Zip(+last4):_____

Physical Address (911 – if different from above)_____

Phone #: (_____)_____ Cell Phone #: (_____)_____

Work Phone #: (____)_____ Ext:_____ ☐ Full Time Student or ☐ Part Time Student

Primary Care Physician (Not Facility) & Phone Number:_____

Date Of Birth:_____/_____/_____ Sex –☐ Male or ☐ Female SS#:_____

Marital Status: ☐Single ☐Divorced ☐Married ☐Partner ☐Separated ☐Widowed Occupation:_____

Employer Name_____

Employer Address:_____

City_____ State_____ Zip_____

Person Responsible if Patient is a Minor:_____

Address & Phone#: (if different from above): _____

Responsible Party Employer Name, Address and Phone #: _____

_____

Social Security Number: _____ DOB: _____

Emergency Contact Information: (Name, Relationship and Phone #)

_____

_____

Primary Insurance: _____ Subscriber:_____

Is Subscriber: ☐ Male or ☐ Female Subscriber SS#: _____ Subscriber DOB: _____

Subscriber Work #: _____ Relationship to Subscriber: _____

Subscriber Employer and Address:_____

Secondary Insurance: _____ Subscriber:_____

Is Subscriber: ☐ Male or ☐ Female Subscriber SS#: _____ Subscriber DOB: _____

Subscriber Work #: _____ Relationship to Subscriber: _____

Subscriber Employer and Address:_____

If you are a patient with military insurance are you: ☐ Active Duty or ☐ Retired Military

E-mail Address: _____

Race: American Indian or Alaskan Native, Asian, African American, Native Hawaiian or other Pacific Islander, White

Ethnicity: Hispanic or Latino / Not Hispanic or Latino Preferred Language: _____

Pharmacy Name and Number: _____

How Did You Hear About Us? _____

PLEASE NOTE: PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE, unless insurance information or an insurance claim form is provided at the time of service. Also, upon visit you will be responsible for any co-pay/deductible/your percentage that has not been met at the time of service. Claims pending over (6) weeks will be your responsibility. Any payment received from your insurance company greater than your outstanding balance will be refunded to you or the insurance company. You are responsible for anything that is not covered by your insurance for today's visit. We bill insurances as a courtesy. If there is any information we request and feel is important for the billing process, (i.e. SSN, Physical address, etc.) and you are not willing to give this information to us you will be responsible for payment in full the date of service and to submit claim to your insurance company yourself. This also authorizes a credit report to be acquired by us if an account is to be established.

_____ _____

Signature Date