Advanced Foot & Ankle Specialists, PC

GENERAL PATIENT INFORMATION

PLEASE PRINT CLEARLY

Personal

Name_____

Date of birth_____ Male _____ Female ____

Marital Status Single____ Married___ Divorced___ Widowed___

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

Cell Phone_____ E-Mail_____

Employment

Employer_____

Occupation_____

Address_____

City_____ State_____ Zip Code_____

Insurance

Subscriber Name_____

Subscriber's Date Of Birth_____

Relationship to Patient Self___ Child___ Spouse___ Parent ____

Emergency Contact

Name_____

Relationship_____

Phone #_____

Primary Care Provider (DOCTOR)

Name_____

Address_____

Phone #_____

***Did you receive a referral from your primary care provider?** Yes___ No___
(If required and not on file, this visit will not be paid by your insurance)

I AUTHORIZE DR.PATTAVINA AND HIS ASSOCIATE(S) TO EXAMINE AND TREAT ME(OR DEPENDENT). I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS THIS CLAIM.

Signature_____ Date_____

Height: _____ Weight: _____ Shoe Size _____

Office use only: Office Ally _____ Amazing Charts _____ Scan _____