The Centers for Foot and Ankle Surgery, LTD

Patient Update

Today's Date ______________________

In an effort to offer you the highest standard of quality patient care, we require that your records be updated if you have not been to our office for one year or more. Please answer the following questions and thank you for your cooperation.

PLEASE PRINT CLEARLY

Patient Information

Patients Name____________________________________

Have you had an address change in the past year? ❒Yes ❒No

If yes, please provide your new address:

____

Street Address Apt. #

____

City State ZIP

Home Phone ___________________________________

Work Phone ___________________________________

Cell Phone____________________________________

Email Address _________________________________

Print please

Insurance

Please present your new card at the front desk to be copied.

Name of Policy Holder _____________________________

Relationship to patient ❒Spouse ❒Parent

Subscriber Date of Birth Mo_____Day_____Year_________

Copay? ❒Yes ❒No How much?____________________

Referral Needed? ❒Yes ❒No

Name of Referring Physician _________________________

Updated Medical Health History

Who is your medical physician? _________________________

When was the last time you saw him/her? _________________

Have you had medical health issues in the past year? ❒Yes ❒No If yes, please list any new conditions and the physician whose care you are under for it

Condition	Physician

Medications

Please provide us with an update of ALL medications you are taking. (***If you have a written list, we can copy it to avoid your having to fill this section out***)

Do you have any allergies? ❒Yes ❒No

If yes, what are they? __________________________________

____

Name of Medication	Strength/Mg	Take how often?

Authorization to Treat

I understand that the information provided on this form is true and correct to the best of my knowledge.

- I request that payments of authorized benefits be made on my behalf for any services furnished by **Foot & Ankle Centers.**
- I authorize any holder of information about me to release any information needed to determine these benefits or the benefits payable to related services to the insurance agent.
- I recognize my financial obligation of any coinsurance, co-pays or deductibles and non-covered services that may be required.
- I hereby give permission to **Foot & Ankle Centers** and any qualified staff to evaluate, diagnose and treat my foot and/or ankle condition as may be deemed necessary.

Patient or Authorized Signature ____________________________________If not patient, state relationship ____________________

Date ____________________________________