Advanced Foot and Ankle Associates
1621 44th St SW, Suite 500 · Wyoming, MI 49509
(616) 538-4442

HEIGHT _____
WEIGHT _____
SHOE SIZE _____

Patient Information *(please print)*

Name: _____
First Last M.I.

Gender: Male / Female (circle one) Social Security #: _____-_____-_____ Birthdate: _____ Age: _____

Marital Status: _____ Email Address: _____

Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Work Phone (____) _____ Cell Phone (____) _____

PCP Information

Primary Care Physician's Name _____ Phone (____) _____

Additional Information

Primary Language: _____ Ethnicity: (Circle One) Hispanic/Latino ***or*** Non-Hispanic/Non-Latino

Race: (Circle One) White/Caucasian American Indian/Alaska Native Asian
Black/African American Native Hawaiian/Other Pacific Islander

How did you hear about us? Physician Friend Yellow Pages Internet Sign Other: _____
(Please circle one)

Employer Information

Employer _____ Department _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Pharmacy Information

Preferred Pharmacy _____ Pharmacy Phone (____)_____

Pharmacy Address _____City_____ State_____ Zip_____

Insurance Card Holder's Information *(if other than patient)* **Relationship to Patient**_____

Name: _____
First Last M.I.

Gender: Male / Female (circle one) Social Security #: _____-_____-_____ Birthdate: _____

Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Work Phone (____) _____ Cell Phone (____) _____

Employer _____ Department _____ Phone (____) _____

Primary Insurance Carrier _____

Emergency Contact

Person to contact in case of emergency_____ Relationship _____

Home Phone (____)_____ Work Phone (____) _____ Cell Phone (____) _____

I agree that if a health care worker of this practice is accidently exposed to blood or other bodily fluids from myself, that I will be tested for HIV and Hepatitis-B. This is in accordance to the State of Michigan, Dept of Health, Act 488 of 1988.

Signature_____ Date_____

I authorize payment of medical benefits by the insured directly to Advanced Foot and Ankle Associates. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself and for any yearly deductible or co-payment amounts. I agree to pay all services within 30days unless a payment plan is negotiated in advance. I authorize Advanced Foot and Ankle Associates to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Signature_____ Date_____

-OVER-