

ADVANCED FOOT AND ANKLE ASSOCIATES  
JAMES E. DEWITT, DPM DANIEL K. KOSCHTIAL, DPM  
MEDICINE AND SURGERY OF THE FOOT AND ANKLE  
1621 44TH ST SW, SUITE 500 • WYOMING, MI 49509 • (616) 538-4442

HEIGHT \_\_\_\_\_  
WEIGHT \_\_\_\_\_  
SHOE SIZE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME/MI \_\_\_\_\_

STREET \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE#(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male Female

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ OTHER \_\_\_\_\_

EMPLOYED? Y \_\_\_\_\_ N \_\_\_\_\_ FULL-TIME STUDENT? Y \_\_\_\_\_ N \_\_\_\_\_ PART-TIME STUDENT? Y \_\_\_\_\_ N \_\_\_\_\_

WHAT TYPE OF WORK DO YOU PERFORM? \_\_\_\_\_

EMPLOYER \_\_\_\_\_ DEPARTMENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

FAMILY PHYSICIAN'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

Address of physician \_\_\_\_\_

Are you currently under his/her care? YES \_\_\_\_\_ NO \_\_\_\_\_ Reason \_\_\_\_\_

WHAT PHARMACY FILLS YOUR PRESCRIPTIONS? Name \_\_\_\_\_ Address \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? PHYSICIAN (NAME) \_\_\_\_\_

FRIEND (NAME AND ADDRESS) \_\_\_\_\_

YELLOW PAGES \_\_\_\_\_ INTERNET \_\_\_\_\_ NEWSPAPER \_\_\_\_\_ SIGN \_\_\_\_\_ OTHER \_\_\_\_\_

IS THIS VISIT WORK RELATED? YES \_\_\_\_\_ NO \_\_\_\_\_

WHO IS RESPONSIBLE FOR PATIENT BILL (Fill in only if other than patient)

SPOUSE \_\_\_\_\_ SSN \_\_\_\_\_ PARENT \_\_\_\_\_ SSN \_\_\_\_\_

GUARDIAN \_\_\_\_\_ SSN \_\_\_\_\_ OTHER \_\_\_\_\_ SSN \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME/MI \_\_\_\_\_

STREET \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE#(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EMPLOYER \_\_\_\_\_

PRIMARY INSURANCE INFORMATION: We will make a copy of your card. If you don't have a card please fill in below.

INSURANCE COMPANY \_\_\_\_\_

POLICY NO \_\_\_\_\_ GROUP NO \_\_\_\_\_

STREET \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE#(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SUBSCRIBER (IF OTHER THAN PATIENT): SPOUSE \_\_\_\_\_ PARENT \_\_\_\_\_ OTHER \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME/MI \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SEX: M F BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER \_\_\_\_\_ SOCIAL SEC # \_\_\_\_\_

SECONDARY INSURANCE INFORMATION: We will make a copy of your card. If you don't have a card please fill in below.

INSURANCE COMPANY \_\_\_\_\_

POLICY NO \_\_\_\_\_ GROUP NO \_\_\_\_\_

I authorize payment of medical benefits directly to James E. DeWitt, D.P.M., P.C. or Daniel K. Koschtial, D.P.M.. I also request payment of government benefits to either myself or to the party who accepts assignment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand that I am financially responsible for any services or materials not covered by my insurance and for any yearly deductible or co-payment amounts. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize the physician to release any information and/or x-rays required to process my claim. This request shall remain in effect until revoked by me in writing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Over please*