WESTMORELAND FOOT & ANKLE

Welcome to our practice!

In order for us to serve you today with your foot care needs and effectively bill your insurance carrier, please fill out this form completely. Thank you in advance.

Patients legal name:_____
FIRST MIDDLE LAST

Preferred name, if different:_____Sex: Male Female

Date of Birth: _____Social Security number:_____
MM/DD/YYYY

PATIENT CONTACT INFORMATION: CHECK IF YOU DON'T HAVE

Email:_____ ☐

Can we send you email notifications about upcoming appointments? Yes No

Mobile phone:_____ ☐

Home phone:_____ ☐

Work phone:_____ ☐

Address:_____
STREETADDRESS CITY STATE ZIP

Patient consent to text and voice messaging YES NO

PAYMENT INFORMATION: ☐CHECK HERE IF YOU ARE SELF PAY AND HAVE NO MEDICAL INSURANCE, then skip this section.

PRIMARY INSURANCE:

Insurance company name:_____

Group ID:_____

Effective date:_____

Relationship to the Subscriber : (circle one) Name & DOB

Self child spouse other

Copay (specialist):$ _____

SECONDARY INSURANCE:

Insurance company name:_____

Group ID:_____

Effective date:_____

Relationship to the Subscriber: (circle one) Name & DOB

Self child spouse other

Copay (specialist):$_____

IMPORTANT!! *If the patient is a child or dependent, or the insurance holder is your spouse, the person who carries the insurance for the patient referred to as your guarantor. We need certain information below for guarantors. If you are not sure, please provide this info anyway. If we do not have it, it can delay processing or reject your insurance claim:

Patient's relationship to guarantor: (circle one) self spouse child other

Guarantor info:_____
FIRST NAME LAST NAME STREET ADDRESS CITY STATE ZIP

_____ MALE FEMALE _____
DOB:MM/DD/YYYY SEX (CIRCLE) SOCIAL SECURITY NUMBER PHONE NUMBER

My preferred language is: ☐English ☐Other:_____

What is the patient's race: (circle) American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander White Decline to specify

Who is your primary care/family doctor? _____ Date last seen _____

_____
STREET ADDRESS CITY STATE ZIP PHONE NUMBER FAX NUMBER

Who is your emergency contact/next of kin?_____
FIRST NAME LAST NAME PHONE NUMER

What is your relation to this person?_____