Elite Foot & Ankle

PATIENT INSURANCE INFORMATION FORM

PATIENT INFORMATION

NAME: _____DATE: _____
First Middle Last

Home Phone ( )_____ Work Phone ( )_____ Ext:_____ Cell Phone ( )_____

Address: _____
Street Apt# City State Zip

E-MAIL Address: _____

Date of Birth _____Social Security # _____Sex: ( ) M ( ) F ; Marital Status_____

Referring Physician/phone #: _____Pharmacy/phone #_____

Other Referring source: ( ) Internet / Google ( ) Family/Friend ( ) Insurance ( ) Yellow Pages ( ) Doctor Referral ( ) Other _____

PATIENT EMPLOYER INFORMATION

Patient's Employer Name: _____

Address: _____
Street City State Zip

Patient's Occupation: _____

Contact Person (at work)_____Contact Phone ( )_____ Fax ( )_____

1) If today's visit is due to an injury at work please check ( )

2) Have you notified your personnel department? ( ) YES ( ) NO

3) Please give brief description of injury:_____

POLICY HOLDER (GUARANTOR) EMPLOYER INFORMATION

Policy Holder Name: _____

Address: _____
Street City State Zip

Policy Holder Date of Birth: _____ SS# _____ Sex: M ( ) F ( )

Policy Holder Employer Name: _____

Address: _____
Street City State Zip

Elite Foot & Ankle

INSURANCE INFORMATION

Primary Insurance Company Name: _____ ID/MEMBER # _____

Group Name: _____ Group # _____

Effective Date: _____ Expiration Date: _____

Patient's Relationship to Policy holder: _____Policy Holder Name:_____

Secondary Insurance Company Name: _____ID/MEMBER # _____

Group Name: _____ Group # _____

Effective Date: _____ Expiration Date: _____

Patient's Relationship to Policy holder: _____Policy Holder Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Address: _____

Home Phone ( )_____ Work Phone ( )_____ Ext:_____

EXPLANATION OF PAYMENT POLICY & INSURANCE FILING PROCEDURES

I hereby authorize ELITE FOOT & ANKLE to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient named above and the facility.

I authorize my insurance carriers to pay benefits directly to ELITE FOOT & ANKLE / Kellvan J Cheng, DPM, PA for any unpaid services filed on my behalf by ELITE FOOT & ANKLE.

I understand that I AM RESPONSIBLE for payment to ELITE FOOT & ANKLE for charges regarding the above patient regardless of my insurance coverage. I also understand that ELITE FOOT & ANKLE is not ultimately responsible for collecting my insurance or negotiating settlements of claims.

Patient / Guardian Signature:_____ **Date:**_____

ELITE FOOT & ANKLE

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