Date _____

Edgebrook Foot & Ankle Clinic
Pratibha Patel, DPM

Patient Information Form

*Please **print** all information in the spaces provided. Be sure to complete and sign the statement at the end of this form.*

Name (Last, First) _____ Date of Birth _____

Street Address _____

City, State, Zip Code _____

Home Phone _____Work Phone _____

Cell Phone _____ Email _____

Sex: □ M □ F Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed □ Long Term Partner

Emergency Contact _____Phone _____

Patient's Employer Name _____Occupation _____

Employer Address _____

Referred By _____

Primary Care Physician _____Phone _____

Physician Address _____

Primary Insurance
Insurance Name _____

Name of Insured _____Date of Birth _____

Relationship to Patient _____

Insured's ID# _____Group# _____

Secondary Insurance
Insurance Name _____

Name of Insured _____Date of Birth _____

Relationship to Patient _____

Insured's ID# _____Group # _____

AUTHORIZATION

I hereby give permission to Edgebrook Foot & Ankle Clinic-Dr. Pratibha Patel to provide treatment and to perform such medical procedures as deemed necessary in the diagnosis and treatment of my current foot condition. I understand that Edgebrook Foot & Ankle Clinic may expect full payment for services rendered at the time of service. I authorize payment of medical benefits billed to my insurance to Edgebrook Foot & Ankle Clinic. I understand and accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____

Printed name of patient or patient's representative

_____

Relationship to the patient