Appalachian Foot and Ankle Associates, P.A.

Patient Information

First Name:_________________ **Middle Initial:**___ **Last Name:**_________________ **Preferred Name:**_____________

Address:____**City:**__________________ **State:**____ **Zip :**______

Home Phone:_____________________ **Cell Phone:**_____________________ **Work Phone:**_____________________

Contact Preference: Home Phone Cell Phone Work Phone

Social Security #: ______________________________ **Date of Birth (MM/DD/YYYY):** ___/___/________

Gender: Male Female **Marital Status:** Single Married Widowed Divorced

Email Address: __________________________________ **Primary Care Provider:** ____________________________

Race(circle): Black/African American White/Caucasian American Indian/Pacific Islander Asian Other Declined

Ethnicity(circle): Hispanic Non-Hispanic **Primary Language(circle):** English Spanish Other

Employer_____________________________________ **Occupation**____

Preferred Pharmacy: ______________________________________ **City/Street:** _______________________________

Primary Insurance ________________________________ **Secondary Insurance**________________________________

Who Carries the Insurance (subscriber)? (circle) Self Parent Spouse Partner Other________________________

Name of Subscriber____ Subscriber DOB_______________________

Subscriber SSN__________________________ Subscriber Employer____

Who is responsible for the patient bill? ☐ Patient is responsible ☐ Other (please list below)

Name: ___________________________________ **Phone #:** ____________________

Address:____**City:**__________________ **State:**____ **Zip :**______

Relationship: ____________________**Date of Birth:** ________________ **Social Security #:** ______________________

How did you hear about our office? ____

Please Note: All copays and unmet deductibles are due at the time of service. It is the patient/guardian's responsibility to know and understand their individual health insurance coverage.