Ambulatory Foot Center

Podiatric Medicine and Surgery
Adults and Children
Foot Specialists

1619 NW Hawthorne Ave. St 110
Grants Pass, OR 97526
(541) 471-7056 Fax (541) 474-3201

PATIENT INFORMATION RECORD

Please print! Please present all your insurance cards to the receptionist to copy for our records.

PATIENT INFORMATION

Full name of patient _____ Birthdate _____

Mailing address _____ Home phone _____

_____ Cell phone _____

Preferred pharmacy _____ Gender: ☐ M ☐ F

Employer/School _____ Marital status _____

Address _____ Race/Ethnicity _____

_____ SS# _____

Work phone _____ Occupation _____

INSURANCE INFORMATION

Primary insurance _____ Secondary insurance _____

Subscriber name _____ Subscriber name _____

ID# _____ Group# _____ ID# _____ Group# _____

Subscriber birthdate _____ SS# _____ Subscriber birthdate _____ SS# _____

Subscriber's relationship to patient _____ Subscriber's relationship to patient _____

If injury related: ☐ On the job ☐ MVA ☐ Other If MVA, what state did injury occur in? _____

If responsible party is someone other than patient, complete info below.

Last name _____ First _____ Middle _____ Phone _____

This person is: ☐ my parent ☐ my spouse ☐ someone else Relationship _____

Address (☐ check if same as patient address) _____

City _____ State _____ Zip _____

SS# _____ Date of birth _____ Employer _____

EMERGENCY CONTACT INFORMATION

(Must be someone not living with you)

Emergency Contact _____

Phone _____

ADDITIONAL DATA

Primary Care Physician _____

Phone _____

Consent Statement: I understand and accept full financial responsibilities to Ambulatory Foot Center P.C. for services rendered (my insurance carrier(s) will not be held directly responsible). I also understand that payment is expected at the time services are rendered. Although I accept full financial responsibility, my primary insurance carrier will be billed as a courtest of this office. I understand that I will be held directly responsible for, and will pay promptly, any remaining unpaid portion of my bill not covered by my insurance. I understand my balance will be carried without a service fee for sixty (60) days. After which, a fee equal to 1.5% (18% APR) of my current balance will be added to my account.

Patient signature _____ Date _____