

**Welcome to the Tola Foot & Ankle Center. Thank you for filling out this Patient Information Form.**

**New Patient**    **Updating my information. Reason for your visit:** \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Jr Sr I II III

Male / Female    SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Birthdate: \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Ext. \_\_\_\_\_    Cell# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Doctor's name, address & phone #: \_\_\_\_\_

**I was referred by:** Dr. \_\_\_\_\_ ; Family / friend \_\_\_\_\_

Phone book ad    Insurance directory    OurWebsite [www.HamiltonPodiatrist.com](http://www.HamiltonPodiatrist.com)   Newspaper Ad

Is a referral needed?    Yes    No    If yes, please hand in referral to our office staff.    Referral received   Y   N

**Emergency Contact:** \_\_\_\_\_ relation \_\_\_\_\_    Phone# \_\_\_\_\_

**Marital status:** Single Married Partner Divorced Widowed ;    **Student**    **Employer:** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_

Effective Date: \_\_\_\_\_ Copay \_\_\_\_\_

Group# \_\_\_\_\_ Ins Plan Name \_\_\_\_\_

Relationship to subscriber:   self   spouse   child

ID #: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Male Female    Birthdate: \_\_\_\_\_

Subscriber: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Subscriber's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

Effective Date: \_\_\_\_\_ Copay \_\_\_\_\_

Group# \_\_\_\_\_ Ins Plan Name \_\_\_\_\_

Relationship to subscriber:   self   spouse   child

ID #: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Male Female    Birthdate: \_\_\_\_\_

Subscriber: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Subscriber's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**If the patient is insured under parents plan, please complete the following:**

Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_

Work Phone# \_\_\_\_\_

Cell# \_\_\_\_\_

**Legal representative: Mother   Father   Both**

Father's Name \_\_\_\_\_

Address: same / other: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_

Work Phone# \_\_\_\_\_

Cell# \_\_\_\_\_

1. **CONSENT FOR TREATMENT:** I give Tola Foot & Ankle Center permission to examine and treat, perform tests and procedures that are necessary in the diagnosis and/or treatment of my foot/ankle/leg disorders.
2. **FINANCIAL POLICY:** I certify that I (or my dependant) have coverage with my insurance and am responsible for informing the office if there is any change in my health insurance information. For my visits in this office, I assign all insurance payments to be payable to Dr. Pamela F. Tola. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I allow the release of medical information to my health insurance for payment, or requested physician for the purpose of treatment and/or to provide continuity of care. I authorize the use of this signature on all health insurance claim form submissions.
3. **PRIVACY NOTICE:** I certify that I have read (or had the opportunity to read if I so chose) and understand the HIPAA Notice of Privacy Practices. Our office's full HIPAA policy is available upon my request.

**SIGNATURE** \_\_\_\_\_

**GUARDIAN SIGNATURE** \_\_\_\_\_