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 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 ☐Newspaper Ad

Is a referral needed? ☐ Yes ☐ No

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 #:_____

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 #:_____

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#_____

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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_____ **Date**_____