

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 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# _____

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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 _____

GUARDIAN SIGNATURE _____