Stonebridge Foot & Ankle
175 Ridge Road, Ste. 800
McKinney, TX 75070
P: (972) 540-0006 F: (972) 984-1102

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ SSN: _____

Address: _____City:_____State:_____ZipCode:_____

Home#: _____ Work#: _____ Cell#: _____

Email Address: _____

What is your preferred method of contact? _____Phone _____SMS _____Email _____Mail

Employed: ___ Y ___ N Occupation: _____

____Married _____Single _____Divorced _____Widowed Sex: ____M____F

Pharmacy & Phone #: _____

Primary Physicians Name/ Phone #:_____

Date Last Seen by Primary Physician: _____

Emergency Contact: _____ Phone #: _____

Relationship to Patient_____ Alternate Phone #: _____

How did you hear about us? (Please circle one):

Physician Internet Insurance Friend Family Other: _____

Current Foot & Ankle Problem: _____

_____

INSURANCE INFORMATION

Primary Insurance Name: _____

ID/ Member #: _____ Group #: _____

Effective Date: _____ Termination Date: _____

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Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Patients relationship to Policy Holder: _____

Secondary Insurance Name (if applicable): _____

ID/ Member #: _____ Group #: _____

Effective Date: _____ Termination Date: _____

Policy Holders Name: _____ Social Security #: _____

Policy Holders Date of Birth: _____ Patients relationship to Policy Holder: _____

EXPLANATION OF PAYMENT POLICY & PRIVACY POLICY

I hereby authorize Christina Salcher, DPM and Stonebridge Foot & Ankle to release medical information pertinent to the filing of insurance claims for me. I authorize my insurance carrier to pay benefits directly to Christina Salcher, DPM, and Stonebridge Foot & Ankle on any unpaid services filed on my behalf. I understand that I AM RESPONSIBLE for payment to Christina Salcher, DPM, and Stonebridge Foot & Ankle for charges for the above patient regardless of my insurance coverage. I also understand that Christina Salcher, DPM, and Stonebridge Foot & Ankle is not ultimately responsible for collecting my insurance or negotiating settlements of claims. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read and understand the Notice. I also hereby give Christina Salcher, DPM, permission to diagnose and administer treatment for my foot and/or ankle condition and authorize any release of information obtained in the course of my treatment.

Patient's Signature: _____ Date: _____

Parent/Legal Guardian's Signature: _____ Date: _____