

Mitchell Foot & Ankle, P.C.

PATIENT INFORMATION

Please Read

Patient's Name:	Age:	Date of Birth:		
Address:	Apt #	Sex:	Home Phone:	
City:	State:	Zip:	Cell Phone:	
SS #	Marital Status:	Work Phone:		
Shoe size :	Best number to contact you:	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work
Employer:	Occupation:			
Insurance Name :	Phone:			
Policy/ID#	Group #			
Name of Primary Doctor:	Phone:			
Hospital:	Date of last Primary Dr.'s visit:			
Name & number of any other treating Doctors:	Phone:			
Who should we thank for referring you?				
Emergency Contact:	Relationship:	Phone:		

REASON FOR VISIT

Please Describe Your Foot and/or Ankle Problem:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so chose- and understand the notice.

I, also, authorize Mitchell Foot & Ankle, P.C. to release any of my chart information to the following persons-: i.e. spouse, mother, father, other relatives, etc. Please print names below. If I do not list any people then my information will not be released without my consent.

Patient Signature:

ASSIGNMENT AND RELEASE

I, hereby, give permission to Dr. Mitchell and his associates/staff to administer treatment, as necessary for the diagnosis and/or treatment of my foot/ankle condition.

I hereby authorize payment directly to Mitchell Foot & Ankle, P.C. for services rendered by Dr. Mitchell and his associates/staff.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits from my insurance carrier. I authorize the use of this signature on all insurance submissions.

I have received information on the Education and Training of Dr. Mitchell.

Signature of Responsible Party:

Date:

MEDICATION LIST

Patient Name:

Birth Date:

In an emergency, contact:

Phone #

At each visit, verify patient prescription medications, overthecounter drugs, herbals and vitamins. If patient is no longer taking the medication, cross it off the list. When adding new medications-, fill in the appropriate columns. Make a copy and give to the patient.

Date	Medications, Overthe –Counter Drugs, Herbals and Vitamins	Strength	Dose	Frequency

Disclaimer: This list if provided to you by this facility as an educational tool. We have noted all the medications you are currently taking, including the medication we have prescribed. This list is prepared based on the information you have provided to us. This facility is not responsible to maintain, prescribe or refill any of the above medications.