

FEITZ FOOT CLINIC

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record

PATIENT INFORMATION

Last Name		First	Middle	() Mr. () Miss () Mrs. () Ms.	Marital Status () Single () Married () Divorced () Widow(ed) () Other	
Is this your legal name? () Yes () No	If not, what is your legal name?		Former Name	Birth Date	Age	Sex () M () F
Street Address		City	State	Zip Code	Home Phone ()	Cell Phone ()
Occupation			Employer	Employer Phone Number ()		
Social Security Number			Primary Care Physician	E-mail Address		
Reason Chose Clinic/Referred by (Please check one) () Dr. _____ () Insurance Plan () Hospital () Family () Friend () Close to Home/Work () Yellow Pages () Other _____						

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND DRIVERS LICENSE TO THE RECEPTIONIST)

Person Responsible for Bill (if different)		Birth Date (if different)	Address (if different)	Home Phone ()		
Employer		Employer Address			Employer Phone ()	
What insurance company?						
Subscriber's Name	Subscriber's SSN	Birth Date	Group #	Policy #	Co-Payment \$	
Patient's Relationship to Subscriber () Self () Spouse () Child () Other						
Name of Secondary Insurance (if applicable)		Subscriber's Name		Group #	Policy #	
Patient's relationship to Subscriber () Self () Spouse () Child () Other						

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone()
		Work Phone()

By initialing to the right and signing below, I acknowledge the above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize release of information for insurance claims purposes. I understand this information may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, HIV and AIDS. INITIAL x _____

ACKNOWLEDGMENT OF HIPAA PRIVACY AUTHORIZATION

By initialing to the right and signing below, I hereby acknowledge that I have read and understand the HIPAA PRIVACY AUTHORIZATION FOR USE and DISCLOSURE of PERSONAL HEALTH INFORMATION. INITIAL x _____

RELEASE OF MEDICAL INFORMATION

By initialing to the right and signing below, I hereby authorize release of my medical records by FEITZ FOOT CLINIC to other physicians and/or clinics involved in my care. Unless specifically denied, FEITZ FOOT CLINIC may also release information on my condition to immediate family members/caregivers. INITIAL x _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY OF FEITZ FOOT CLINIC

By initialing to the right and signing below, I hereby acknowledge that I have received and understand the FINANCIAL POLICY. INITIAL x _____

X

PATIENT/GUARDIAN SIGNATURE

DATE