TIDEWATER
Foot & Ankle Associates

Patient Information

Date: _____ DOB: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred contact: Home Cell

E-mail: _____ Decline Marital Status: S M D W

Race: _____ Decline Ethnicity: Hispanic Non-Hispanic Decline

Sex: M F SS#: _____ **How did you hear about us?** _____

Pharmacy Name: _____ Pharmacy Phone/Crossroad: _____

Patient Employment

Employer: _____ Address: _____

Occupation: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Phone: _____ Relation to patient: _____

Designated Persons

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment, and healthcare operations) with people listed below. This authorization will remain in effect until revoked in writing.

Name: _____ Phone: _____ Relation to patient: _____

Name: _____ Phone: _____ Relation to patient: _____

Permission for treatment

I, the undersigned (patient/ parent/guardian), hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by Tidewater Foot & Ankle Associates deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatment. I authorize the release of any of my past and/or current medical records that may be needed for my treatment from any of my health providers.

HIPAA Privacy Notice

I acknowledge that I was offered a copy of the Notice of Privacy Practice and have read, or had the opportunity to read, and understand the notice.

I certify that I have read and understand all of the above information. I understand that medical information is necessary to provide me with medical care in a safe and efficient manner. I am authorizing treatment and authorizing my insurance company to be billed for that treatment. I request that payment for services furnished to me be paid directly to Tidewater Foot & Ankle associates. I understand that it is my responsibility to pay any deductible, copay, co-insurance, or any other balance not covered by my insurance company. My signature below acknowledges confirmation for authorization or assignment of Medicare or private insurance. By providing my email address, I agree to allow Tidewater Foot & Ankle Specialists to send me an email invitation to register for the Tidewater Foot & Ankle Associates portal and to send me other emails regarding their services. I will notify you of any changes in my status or changes in the above information.

Signature: _____ Date: _____