WOODLY
FOOT & ANKLE SPECIALISTS, PC

Today's Date:_____

PLEASE PROVIDE YOUR INSURANCE CARD (S) AND PHOTO ID

PATIENT'S LAST NAME: FIRST NAME:

PATIENT'S ADDRESS:

CITY: STATE: ZIP

HOME PHONE: CELL PHONE:

DATE OF BIRTH: SOCIAL SECURITY NUMBER:

GENDER: F M SHOE SIZE: HEIGHT: WEIGHT:

MARTIAL STATUS: SPOUSE'S or PARENT'S NAME:

MY FOOT PROBLEMS ARE:

HOW LONG HAVE YOU HAD THE PROBLEM(S): DAYS: WEEKS: YEARS:

INSURANCE INFORMATION

ARE YOU THE INSURED: Y N If NO - NAME OF INSURED:

PRIMARY INSURANCE: GROUP #

POLICY# EFFECTIVE DATE

SECONDARY INSURANCE: GROUP #

POLICY# EFFECTIVE DATE

COMPLETE THIS SECTION ONLY IF NAME OF INSURED IS DIFFERENT FROM PATIENT

LAST NAME: FIRST NAME: GENDER: F M

INSURED'S ADDRESS:

CITY: STATE ZIP

HOME PHONE: WORK PHONE:

INSURED'S DATE OF BIRTH: SOCIAL SECURITY NUMBER:

WHAT IS THE INSURED'S RELATIONSHIP TO THE PATIENT:

PLEASE COMPLETE THIS SECTION

Email Address: _____ **Pharmacy:** _____

PRIMARY CARE PHYSICIAN _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

PHONE: _____ DATE OF LAST VISIT: _____

X _____ _____

PATIENT SIGNATURE (OR PARENT/GUARDIAN SIGNATURE IF PT IS a MINOR) DATE:

WOODLY
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TODAY'S DATE: _____

Due to Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information must be filled out by each patient annually.

I authorize Charlton G. Woodly, DPM to release my medical or insurance information necessary to process my medical claims and coordinate or manage my healthcare.

YES NO

In the event a family member or caregiver attends your office visits and is the exam room at the time of your evaluation and/or treatment, I give Dr. Charlton G. Woodly, DPM of Woodly Foot and Ankle Specialists, and its physicians or employees my permission to discuss freely my condition, treatment, or diagnosis with that person.

YES NO

Does Dr. Charlton G. Woodly, DPM have permission to send a copy of your treatment note to your Primary Care Physician per his/her discretion?

YES **NO**

'lease provide the numbers below where we have consent to leave a message:

May we leave a message at your home? **YES** **NO** HOME PHONE: _____

May we leave a message at your work? **YES** **NO** WORK PHONE: _____

May we leave a message on your cell? **YES** **NO** CELL PHONE: _____

May text you? **YES** **NO** CELL PHONE: _____

With whom may we discuss or release information about your care, treatment or diagnosis?

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

NAME: _____ PHONE: _____ Relationship to you? _____

How Did You Hear About Us or Whom May We Thank For Referring You

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient/Parent/Guardian Signature _____ **DATE SIGNED:** _____

PRINT PATIENT'S NAME: _____