Ankle and Foot Clinic of Idaho

1. Patient Information

Date / /20

Name: _____ Birth Date ____/____/____ Sex: M F
(First) (MI) (Last)

Address: _____ Home Phone: _____

City: _____ State _____ ZIP _____ Cell Phone: _____

Social Security Number: _____ Email: _____

Employer/School: _____ Pharmacy: _____
(name) (city) (name) (city)

Emergency Contact: _____
(name) (relationship) (phone)

Primary Doctor: _____ Referring Doctor: _____
(name) (city) (name) (city)

How did you hear about us? _____

2. Communication

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

☐ **HOME PHONE** ☐ **CELL PHONE**	☐ **WRITTEN COMMUNICATION**
☐ **May leave a message with detailed information.** ☐ **Leave message with call-back number only**	☐ **Mail to my home address.** ☐ **Mail to my work/office address** ☐ **Fax to this number:**

3. Financial and Insurance Information

☐ **Insurance card copy attached to file**

Primary Insurance:	Member #		Group #
Policy Holder (if different than patient)	Relation to Patient	Birthdate	Home Phone:
Address	City	State	Zip
Employer		City	Work Phone:
Secondary Insurance:	Member #		Group #
Policy Holder (if different than patient)	Relation to Patient	Birthdate	Home Phone:
Employer		City	Work Phone:

4. Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the *Notice of Privacy Practices* from the Ankle and Foot Clinic of Idaho. I understand that it is for me to keep and that I have read and understood the notice. This acknowledgment is required per government statute.

_____ _____
Patient Name (please print) Legal Guardian (if under 18)

_____ _____ _____
Signature Date Relationship to patient