# NORTHERN CALIFORNIA FOOT AND ANKLE CENTER

ROBERT S. SALK, D.P.M. KIRK A. GROGAN, D.P.M NITZA N. RODRIGUEZ, D.P.M. MARK S. CO, D.P.M.
Davies Campus - 45 Castro St, Suite 315 San Francisco, CA 94114
California Campus - 3838 California St, Suite 108 San Francisco, CA 94118

Name ____________________________________________ Birth Date ______/______/_____ Age ________ (years)
(First Middle Last) (month / day / year)
SS# ___________-_________-_____________ Ethnicity __________________________ Sex: Male Female

Home Address_________________________________,_____________________ State________ Zip _____________
Street Number / Street Name / Apt. # City

Home Phone (_______)_______-_________ Work Phone (______)_______-_________ Work Extension _____________

Cell Phone (______)_______-__________ E-Mail _______________________________@______________________

Married Single Domestic Partnered Other (i.e.: Widowed) Full-Time Student Part-Time Student

Employer Name ____________________________________ Employment Status_____________________________

Employer Address______________________________,____________________ State_______ Zip ______________
Street Number / Street Name / Suite # City

Parent or Responsible Party Name _______________________________ Relationship to Patient _______________
Under 18 Complete Responsible Party Information
Address if Different from Home ___________________________________ Day Phone (______)________-__________

Spouse / DP Name ___________________________________________ Day Phone (______)________-__________

Emergency Contact Name & Relationship to Pt_______________________________ Day Phone (______)________-__________

Primary Care Dr.____________________________________________________________________
Last Name, First Name
Physician Address _______________________________________ Physician Phone (______)________-__________

How did you choose NCFAC for your Podiatric needs? Physician Referral Insurance Website Other Medical Referral Yelp Review Family Member Friend/Colleague Other: _______________________________________________

**Copy of Insurance ID(s) and Mandatory Completion Required From Computer Billing Service / (415)683-3223**

Primary Insurance Company ____________________________PPO HMO Co-pay Amount $_____________

Are you the Subscriber or Primary Policy Holder on this Insurance? Yes No **If No Complete Subscriber Information**

Name of Subscriber (Policy Holder) ____________________________ Subscriber Birth Date _____/_____/______

Patient's Relationship to Subscriber_______________ Subscriber's Employer ____________________________
(i.e.: Spouse, Child, Other)
Do you have Additional Health Insurance? Yes No Secondary Insurance Co___________________________

Name of Subscriber 2nd Insurance ______________________________ Subscriber Birth Date _____/_____/______

Patient's Relationship to Subscriber_______________ Subscriber's Employer ____________________________
(i.e.: Spouse, Child, Other)

Is visit related to accident or injury? Yes No If Yes, Type Injury: Auto Work Other Date of Injury___________

Place of Injury _____________________ How were you injured? ____________________________________

Assignment of Benefits: I hereby assign payment directly to Northern California Foot & Ankle Center, the insurance benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization. I also authorize a photocopy of this assignment as if it were an original copy. If it becomes necessary for the account to be referred to an attorney for collection or suit, the undersigned shall pay the reasonable attorney's fee and collection expenses. Further, I understand that coinsurance, unsatisfied deductible

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amounts, etc. are requested at the time of services unless other financial arrangements are made in advance. I understand that if I don't keep my scheduled appointment or if I don't cancel my appointment at least 24 hours in advance, I will be charged a $65.00 missed appointment fee.

________________________________________ ___________________________________

Signature Date