WELCOME TO ANKENY FOOT & ANKLE SPECIALISTS
CERVETTI & ASSOCIATES
PATIENT INFORMATION

Full Name ________________ ______________ Age _______ Birth Date _________ _____

Name you use (if other than above)________________ Home Phone __________________ Sex _______

Address _________________ ______________ City __________________ State ____ Zip _____________

Height ______________ Weight ______________ Marital Status __________

Employer ___________ ___________ _________ Occupation _____________Work Phone _____________

Social Security Number _________________________ Cell Phone # ______________________________

Person To Contact In Case of Emergency ____________________ ___________ Phone ________________

Primary Care Doctor __________________ E-Mail Address: _________________________________

How Did You Hear About Our Office? *Press Citizen* __ *Ankeny Register* __ *Internet Search* __

Phone Book __ *Insurance Company* __ *Referred by Physician* __ *Friend or Family* __ *Patient* __

Person Who Referred You? __________________*Other* ___________________________________.

Do you wish for our office to contact you prior to your future appointments and remind you of time and date? ___yes ___no May we leave a message? __yes __no How do you wish to be notified? ___ telephone call to residence ____cellular or mobile phone _____e-mail

If you would like our office to file a claim with your insurance company on your behalf, please complete the information below. The Patient Confidentiality Act mandates that a valid release of information form (effective for a six-month period) be maintained by our office. Your signature below will allow us to file your insurance claim for you. If you are uninsured or choose to self pay, please make payment arrangements.

Are we seeing you for a work-related Injury? Yes _____ No ______ Contact Person ______________________________

Workman's Compensation Insurance Carrier ____

Phone ____________ Address ___________________________ City _______________ State/Zip __________

INSURANCE INFORMATION

Primary Insurance Co. ______________________ Policy # ____________________ Group # ______________

Name of Policy Holder _____________________ Social Security Number ________________________

Birth Date _______________ Sex _____ Relationship to Patient _________________________

Address ______________________________ City ____________________ State ________ Zip _____________

Place of Employment ________________________ _______ Work Phone # _______________

Secondary Insurance ______________________ Policy # ____________________ Group # _____________

Name of Policy Holder _____________________ Social Security Number ________________________

Birth Date _______________ Sex _____ Relationship to Patient _________________________

Address ______________________________ City ____________________ State ________ Zip _____________

Place of Employment ________________________ _______ Work Phone # _______________

Other Insurance Coverage _________________ __________

I request that payment of benefits be made to me or on my behalf to Cervetti & Associates (Ankeny Foot & Ankle Specialists) for services rendered. I authorize any holder of medical or other information about me to release any information needed to determine these benefits of benefits for related services. <u>This authorization is effective for six months after the date it is signed.</u>

Signature _______________ _______ Date __________________

ROS: ________________ Date: ______________