Ankle & Foot Associates

PODIATRY DEMO FORM

DEMO. 01-21

Orange Park 981 Kingsley Ave (904) 269-9595 | **Jacksonville Beach** 2710 3rd St South (904) 269-9595

Name _____ Date _____

Date of Birth _____ Age _____ ☐ Male / ☐ Female

Race ☐ White ☐ African-American/Black ☐ Latino ☐ Asian ☐ Other _____

Ethnicity ☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino

☐ Married ☐ Divorced ☐ Single ☐ Other

Dominant Hand ☐ Right ☐ Left

Language(s) ☐ English ☐ Other _____

Street Address _____

City _____ State _____ Zip Code _____

Cell# _____

Home# _____

May we leave a message on your home and/or cell? ☐ Yes ☐ No

May we contact you at work? ☐ Yes ☐ No

Phone is our primary method of contact unless you indicate otherwise here _____

Email _____*

By providing us your email you agree to allow us to communicate such items as: appointments, billing statements, pt. portal and general office topics. We will not share your email with anyone. This is not a means of two-way communication, it is a send-only email from our office. There is some level of risk with any email communication that information could be intercepted and read by a third party. You may revoke this consent at any time. Please notify us if your email address has changed and remember to check your spam if looking for communication from us.* ***Do not send medical/ appointment information via email.*

Place of Employment _____ Work# _____

Emergency Contact Name _____

Relationship _____ Phone# _____

Primary Insurance _____ Secondary Insurance _____

Pharmacy Name _____ Address _____

Who can we discuss your medical or billing issues with?

☐ Emergency contact ☐ Spouse ☐ Significant other ☐ Parent ☐ Adult child ☐ No one

Do you give us consent to share medical history/information with your healthcare providers?

☐ Yes ☐ No**

Do you give us consent to share medication history with your pharmacy?

☐ Yes ☐ No**

***If no, please alert staff. If you have specific restrictions on who may not obtain your patient health information, you must request and complete a RESTRICTION REQUEST FORM.*

How did you hear about us? ☐ Google Search ☐ Social Media ☐ Location ☐ Insurance ☐ Family/Friend ☐ Physician (*Name* _____) ☐ Other _____

I certify the information given above is true and correct to the best of my knowledge.

PRINTED PATIENT NAME :	INITIAL:	DATE: