

ANKLE AND FOOT ASSOCIATES  
ORANGE PARK, JACKSONVILLE BEACH, ST. AUGUSTINE

TODAYS DATE \_\_\_\_\_

NAME \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ CIRCLE MARRIED DIVORCED SINGLE \_\_\_ OTHER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

CELL # \_\_\_\_\_ HOME # \_\_\_\_\_ WORK# \_\_\_\_\_ PLACE OF EMPLOYMENT: \_\_\_\_\_

EMERGENCY CONTACT NAME & RELATIONSHIP \_\_\_\_\_ THEIR PHONE# \_\_\_\_\_

MAY WE CONTACT YOU AT WORK ? \_\_\_ YES \_\_\_ NO MAY WE LEAVE A MESSAGE ON HOME AND/ OR CELL ? \_\_\_ YES \_\_\_ NO

PHONE IS PRIMARY METHOD OF CONTACT UNLESS YOU INDICATE OTHERWISE HERE \_\_\_\_\_.

E-MAIL ADDRESS \_\_\_\_\_ @ \_\_\_\_\_ THIS IS CONSIDERED CONSENT.

\*\*\*By providing us your e-mail you agree to allow us to communicate such items as appointments, billing statements, pt. portal, and general office topics. We will not share your e-mail with anyone. This is not a means of two way communication, it is a send only e-mail from our office. There is some level of risk with any e-mail communication that information could be intercepted and read by a third party. You may revoke this consent at anytime. Please notify us if your e-mail address has changed and remember to check your SPAM if looking for communication from us. **DO NOT SEND MEDICAL/APPOINTMENT INFORMATION VIA E MAIL.**

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_

NAME OF PHARMACY \_\_\_\_\_ STREET ADDRESS: \_\_\_\_\_

IF NECESSARY MAY WE DISCUSS YOUR MEDICAL ISSUES WITH A SPOUSE? Y N , SIGNIFICANT OTHER Y N , ADULT CHILD Y N

DO YOU GIVE US CONSENT TO SHARE MEDICAL HISTORY/INFORMATION WITH YOUR HEALTHCARE PROVIDERS? Y N IF NO ALERT STAFF

DO YOU GIVE US CONSENT TO SHARE MEDICATION HISTORY WITH YOUR PHARMACY? Y N IF NO 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, NOTIFY THE STAFF.**

ETHNICITY: Select one \_\_\_\_\_ Non-Hispanic/Non-Latino \_\_\_\_\_ Hispanic/Latino

RACE: Select one \_\_\_\_\_ White \_\_\_\_\_ African-American/Black \_\_\_\_\_ Other

LANGUAGE: \_\_\_\_\_ DOMINANT HAND: Right Left

HOW DID YOU HEAR ABOUT US ? INTERNET/WEB, PHYSICIAN, LOCATION, INSURANCE, FAMILY/FRIEND, OTHER \_\_\_\_\_

**\*\* I CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. Initial \_\_\_\_\_ Date \_\_\_\_\_**