PATIENT INFORMATION

Dr. Dan Bangart Dr. Keith Bangart Dr. Jeff Thomas Dr. Shane Moore Dr. Ryan Bangart

Patient's Name ______________________ Patient's Social Security ______________________

Patient's Address (local) ______________________ Birthdate ____/____/________ Age ______

City __________ State ______ Zip __________ Sex: M F Marital Status: S M D W Sep Other

Phone # (local) ______________________ Spouse Name ______________________

Cell Ph # ______________________ Permanent Address ______________________

Responsible Party (if minor) ______________________ City __________ State ______ Zip ______

Responsible Party Address ______________________ Responsible Party Phone # ______________________

City __________ State ______ Zip __________ Email ______________________

Meaningful Use:

Race (Select One): American Indian Asian Black Hispanic or Latino Pacific Islander White Other (indicate) ______________________

Primary Language: ______________________

EMPLOYMENT INFORMATION Patient/Parent Occupation ______________________

Patient/Parent Employer ______________________ Spouse's Employer ______________________

Employer Address ______________________ Employer Address ______________________

City __________ State ______ Zip __________ City __________ State ______ Zip ______

Employer Phone # ______________________ Employer Phone # ______________________

INSURANCE INFORMATION – We will copy your insurance card but we need you to fill out this section!

Primary Insurance ______________________ Secondary Insurance ______________________

Ins Co Address ______________________ Ins Co Address ______________________

City __________ State ______ Zip __________ City __________ State ______Zip ______

Ins Co Phone # ______________________ Ins Co Phone # ______________________

Cardholder Name ______________________ Cardholder Name ______________________

Relationship to Patient ______________________ Relationship to Patient ______________________

Group #__________ ID # ______________________ Group # ______ ID # or SS# ______________________

Insured Date of Birth ______________ Sex M F Insured Date of Birth ______________ Sex M F

ACCIDENT INFORMATION

Date of Accident __________ How/Where ______________________

Work Related: Y N Were you treated by another Doctor for this injury? Y N

Doctor's Name ______________________ Phone # ______________________

Family Doctor ______________________ Phone # ______________________

Former Podiatrist ______________________ Phone # ______________________

Referred by ______________________

By signing this document:

1. I hereby give my permission to administer treatment, and to perform such procedures as may be necessary in diagnosis and treatment.
2. I will furnish insurance forms & information and I agree to pay my co-payment, deductible and non-covered portions at the time of my visit or when billed by the office.
3. *Minors* I agree that I am the legal guardian of this patient, and understand that **only** the legal guardian is allowed in the exam room.
4. I understand that a photograph may be taken of me for insurance verification purposes, and if I disagree with this process I will let the office know.

Patient Signature: ______________________ Date: ______________