Lafayette Podiatry Associates
2020 Union Street, Suite 100
Lafayette, IN 47904
(765) 449-4758

Patient Information:

Patient Name: _____ **Gender**: ❑**M** ❑ **F**
First **Middle** **Last**

SSN: _____ **DOB**: _____ **Email**: _____

***Is the patient a MINOR or have a POWER OF ATTORNEY? YES❑ NO❑ (If yes, please ask for corresponding paperwork.)**

Billing Information:

Mailing Address: _____
Street **City** **State** **Zip Code**

Home Phone: (_____) _____-_____ **Work Phone**: (_____) _____-_____

Cell Phone: (_____) _____-_____ **Upon contact, whom may we speak with**: Patient | Spouse | Parent

Employer: _____ **Employer Phone**: (_____) _____-_____

Emergency Contact: _____ **Emergency Phone**: (_____) _____-_____

Government Mandated Information: (ALL fields required) Primary Language: _____

Race: American Indian | Asian | Pacific Islander | African American | Caucasian **Ethnicity**: Hispanic/Latino | Non-Hispanic/Non-Latino

Marital Status: Single | Mar | Div | Wid **Student Status**: Part-time | Full-time | N/A **Employment Status**: Part-time | Full-time | N/A

Insurance Information: (ALL fields required if policy holder is not the patient, if policy holder is the patient simply circle self)

Primary Insurance Company: _____ **Policy Holder's Name**: _____

Birthdate: _____ **Policy holder's relationship to patient: Self | Father | Mother | Spouse | Other**_____

Secondary Insurance Company: _____ **Policy Holder's Name**: _____

Birthdate: _____ **Policy holder's relationship to patient: Self | Father | Mother | Spouse | Other**_____

Attention:

- I authorize the release of all information to my insurance companies, workers compensation carriers, and/or other treating physicians.
- I authorize and request insurance payment directly to Lafayette Podiatry Associates, P.C.
- I understand that I am responsible for my bill.
- I authorize use of this form on all of my insurance submissions.
- I authorize Lafayette Podiatry Associates, P.C. to act as my agent in helping obtain payment from my insurance companies and to help me obtain any required pre-certification.
- I agree to pay for my bill in full plus court costs, attorney fees, and all collection fees if deemed necessary.
- If insurance deems my procedure medically unnecessary, I will be responsible for payment.
- I authorize the physicians of Lafayette Podiatry Associates, P.C. to treat my foot/ankle problems.

_____ _____

PATIENT/PARENT SIGNATURE **DATE**

Medical History

Patient Name: _____ **DOB:** _____ **Shoe size:** _____

Height: _____ **Weight:** _____ **Do you have Diabetes?** Y N

Primary Physician: _____ **Referring Physician:** _____

Pharmacy & Location: _____

What type of foot/ankle problem are you having? _____

_____

Do you exercise or participate in any types or sport activities, what type? _____

_____

Do you smoke? Y N **Packs per day**: _____ **Number of Years**: _____

Do you use alcohol? Y N **If yes, please circle how often?** Rarely Often Socially

Medications Name & Dose: Allergies:

Surgical History:

Medical History: (please check all that apply)

Arthritis	**Cancer**	**Gout**	**Heart Attack**	**Hepatitis**
High Cholesterol	**HIV/Aids**	**Injury/Fracture**	**Osteoporosis**	**Stroke**
Rheumatoid Arthritis	**Diabetes 1 or 2**	**Ulcers**	**High Blood Pressure**	**Kidney Disease**
Thyroid Disease	**Other**	**Other**	**Other**	**Other**

_____ _____

PATIENT/PARENT SIGNATURE **DATE**