ADVANCED FOOT & ANKLE CLINIC
3730 PLAZA WAY SUITE 6500
KENNEWICK WA 99338

PHONE: 509-585-3622
FAX: 509-585-3624

PATIENT INFORMATION:

Please Print

PATIENT'S NAME: ______________________________ SEX __ MALE __ FEMALE
(LAST) (FIRST) (MIDDLE)

ADDRESS: ______________________ APT: ____ CITY ________ STATE ____ ZIP ______

DATE OF BIRTH: ______________ AGE: ________ SOCIAL SECURITY# ______ - ____ - ______

PHONE: (HOME) ______________ (WORK) ______________ (CELL) ______________

E-MAIL ______________________ EMPLOYER ______________________

EMERGENCY CONTACT ______________ RELATIONSHIP ______________ PHONE ______________

GUARANTOR/RESPONSIBLE PARTY INFORMATION:

NAME: ______________________________ RELATIONSHIP: __________
(LAST) (FIRST) (MIDDLE)

ADDRESS: ______________________ APT: ____ CITY ________ STATE ____ ZIP ______

DATE OF BIRTH: ______________ AGE: ________ SOCIAL SECURITY# ______ - ____ - ______

PHONE: (HOME) ______________ (WORK) ______________ (CELL) ______________

EMPLOYER: ____

INSURANCE INFORMATION:

PRIMARY INSURANCE: ______________ SUBSCRIBER: ______________ DOB: ________

ID NUMBER: ______________ GROUP NUMBER: ______________
(If applicable)

Patient's relationship to insured: ___ Self ___ Spouse ___ Child ___ Other: (Please list) ______________

INSURED'S EMPLOYER: ______________________ PHONE: ______________

SECONDARY INSURANCE: ______________ SUBSCRIBER: ______________ DOB: ________

ID NUMBER: ______________ GROUP NUMBER: ______________
(If applicable)

Patient's relationship to insured: ___ Self ___ Spouse ___ Child ___ Other: (Please list) ______________

INSURED'S EMPLOYER: ______________________ PHONE: ______________

RESPONSIBILITY FOR PAYMENT OF SERVICES

I hereby authorize my health insurance carrier(s) to make payment of any benefit due me directly to **Dr. Travis S. Carter**. I acknowledge and understand that I am responsible for all charges for services rendered to me or my dependents, at the time of service, unless prior arrangements have been made. I am responsible for any services not covered by my insurance. I agree to pay any balance owing on my account promptly upon receiving my statement. I agree to pay any attorney fees and collections costs.

I consent to **Dr. Travis S. Carter** to furnish my insurance company and Medicare any information regarding my care as may be requested. A copy of this agreement is considered as an original for insurance purposes.

DATE: ______________ **SIGNATURE:** ______________________________
SIGNATURE OF PATIENT OR PARENT/GUARDIAN