Foot & Ankle Specialists of the Mid-Atlantic
Keeping you on track...For Life!

# PATIENT DEMOGRAPHICS

**First Name** _____ **M.I.** _____ **Last Name** _____

**Street Address** _____ **Apt. #** _____ **City** _____ **State** _____ **Zip code** _____

**Home Phone** (_____) _____ **Work Phone** (_____) _____ **Cell Phone** (_____) _____

**E-Mail Address** _____

**Gender** ☐ **F** ☐ **M** **Birth Date** ____/____/____ **Marital Status** ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

**Primary Language** _____

**Race: (Choose all that apply)**

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White

**Ethnicity: (Choose one that applies)**

☐ Hispanic
☐ Not Hispanic

**Employed** PT / FT / Retired / None **Employer** _____

**Pharmacy of Choice** _____ **Pharmacy Address** _____

**Primary Care Physician** _____

**Are you diabetic?** Yes No **If yes, name of physician managing diabetes** _____ **Date last seen** _____

**How did you hear about our practice?** ☐ Health Fair ☐ Doctor Referral (Name of Doctor: _____)

☐ Internet (Source _____) ☐ Ad (Source _____)

☐ Friend/Family Member/Patient (Name: _____) ☐ Other: _____

**Emergency Contact** _____ **Relationship to Patient** _____

**Cell Phone Number** (_____) _____ **Alternate Phone Number** (_____) _____

**Insurance Information**

A. Insurance Company: _____
Insurance ID Number: _____
Group Number: _____
Primary Subscriber Name: _____
Primary Subscriber Birth Date: _____
Relationship to Patient: _____

B. Insurance Company: _____
Insurance ID Number: _____
Group Number: _____
Primary Subscriber Name: _____
Primary Subscriber Birth Date: _____
Relationship to Patient: _____

**Financially Responsible Person First Name** _____ **Last Name** _____
**Gender** ☐ **F** ☐ **M** **Birth Date** __/____/____ **Street Address** _____
**City** _____ **State** _____ **Zip code** _____
**Home Phone** (_____) _____ **Work Phone** (_____) _____ **Cell Phone** (_____) _____

**Patient's Authorization and Assignment of Benefits:** I hereby authorize the processing of the medical insurance either by electronic or manual method by FASMA, LLC. My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered to FASMA, LLC. I certify that the information, I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I grant permission to contact me via email. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I recognize my financial obligation of any balance, co-insurance, deductible, and non-covered services that may be required.

**Signature of Responsible Party** _____ **Date** _____

**Relationship (if not patient)** _____