valley foot & ankle pc

Dr. David Croshaw ♦ Dr. Brandon D. Wilde

Patient Information

Date:_____

Name: _____ Phone: _____ Cell_____
(First) (Last) (Initial)

Address: _____ City:_____ ST: _____ Zip: _____

Email Address: _____ Preferred Communication: Email, Letter, Phone, Fax_____
(Circle) (Number)

Date of Birth: _____ Age_____ Sex:_____ Martial Status: _____ SS#_____

Guarantor or Spouse _____ SS# _____Relationship: _____ Date of birth_____

Address: _____ City: _____ ST: _____ Zip: _____

How did you hear about us? Friend/Family _____Phonebook____ myfoot-ankle.com____
(Whom may we Thank?) (Check)

Facebook____ Twitter____ Newspaper____ Radio____ Other_____
(Please List)

Employer: _____Occupation: _____ Work Phone: _____

Primary Insurance: _____ Policy #: _____ Group #:_____

Policy Holder: _____SS#: _____Relationship: _____ Date of Birth: _____

Secondary Insurance: _____ Policy #: _____ Group #:_____

Policy Holder: _____ Relationship: _____ Date of Birth: _____

Spouse: _____ Employer: _____ Phone: _____

Nearest relative not living at home: _____ Relationship _____Phone: _____

Address_____ City_____ State_____ Zip+_____

Emergency contact: _____ Phone: _____

Please note: As a service to you, we may send a report to your Primary Physician about your foot problem and our treatment plan. If you object to this, please let us know.

Agreement: I authorize Dr. David K. Croshaw, Dr. Brandon D. Wilde and/or assistants to render proposed examination and treatment. I authorize release of any medical records necessary to facilitate consultation on my care, or to process insurance claims. I also authorize direct payment of all related insurance benefits to Valley Foot & Ankle. I accept full responsibility for professional services and materials provided in rendering treatment, as well as any account service charges which apply.

I acknowledge that I was provided a copy of the Notice of Privacy Practices & that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Date:_____ Signature: _____
(Patient or Responsible Party)