Foot & Ankle INSTITUTE

281 531-4100
www.TXFAI.com

SAMUEL MENDICINO, D.P.M.
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PLEASE COMPLETE ALL INFORMATION AND PRINT CLEARLY

Today's Date: _____ Social Security # _____ Sex: ☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ W ☐ D Birth Date: _____ Age: _____

Patient's Full Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

List your employer, or if completing this for a minor, please list parents' employment. Email: _____

Employer: _____ Address: _____ Occupation: _____

Spouse's Name: _____ Spouse S.S.# _____ Birthdate: _____

Spouse's Employer: _____ Address: _____ Work Phone _____

Is Patient a Student ☐ Y ☐ N If yes, ☐ Full-Time ☐ Part-Time School Name: _____

In case of emergency, who may we contact? Name: _____ Phone: _____

Name and address of your family doctor: _____

When was your last visit to him/her and why?: _____

How were you referred to us? ☐ Another Patient ☐ Friend/Relative ☐ Doctor ☐ Insurance Directory

☐ Internet ☐ Yellow Pages ☐ Newspaper ☐ Other _____

If referred by patient or doctor, what is his/her name? _____

Is this claim related to an accident or injury? ☐ No ☐ Yes, if yes related to: ☐ employment ☐ personal ☐ auto

Date of injury: _____ What are your symptoms for today's visit? _____

_____

Responsible party for payment of claim: _____

Name of Pharmacy: _____ Phone: _____

PLEASE COMPLETE ALL INFORMATION AND PRESENT INSURANCE CARD TO RECEPTIONIST

PRIMARY INSURANCE

Name of insurance carrier: _____

Address for claims: _____ Phone: _____

ID# (policy #): _____ Group plan# _____

Subscriber's name: _____ Date of Birth: _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child

SECONDARY INSURANCE

Name of insurance carrier: _____

Address for claims: _____ Phone: _____

ID# (policy #): _____ Group plan# _____

Subscriber's name: _____ Date of Birth: _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child

OVER PLEASE

To the best of my knowledge the above information is correct. I hereby give my permission to the Foot & Ankle Institute and its employees, to administer treatment and to perform such procedures as may be deemed necessary in the diagnoses and/or treatment of my foot/ankle condition.

Signature of patient (or parent if minor) _____ Date _____

SIGNATURE ON FILE:

I hereby authorize Centers For Advanced Foot Care d.b.a. the Foot & Ankle Institute to submit a claim to my insurance carrier or it intermediaries for all covered services rendered by the physician, and direct my insurance carrier or its intermediaries to issue payment check(s) directly to Centers For Advanced Foot Care. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information need to determine these benefits or the benefits payable for related services.

I understand that I am financially responsible to the Foot & Ankle Institute for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient (or parent if minor) _____ Date _____

MEDICAL RECORDS ACCESS:

I authorize Foot & Ankle Institute and its employees to have complete access to medical records from West Houston Medical Center or from any other hospital facility.

Signature of patient (or parent if minor) _____ Date _____