

# Foot & Ankle Specialists *of the Mid-Atlantic*

*Keeping you on track...For Life!*

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
 Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex  F  M Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital Status \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**Check One: Race:**  
 American Indian or Alaska Native  
 Asian  
 Black or African American  
 Native Hawaiian or other Pacific Islander  
 White  
 Not Specified

**Ethnicity:**  
 Hispanic  
 Not Hispanic  
 Not Specified

**Primary Language:** \_\_\_\_\_  
**Pharmacy of Choice:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**If diabetic, Physician managing diabetes** \_\_\_\_\_

**How did you hear about our practice?**

Health Fair  Doctor Referral  Internet  Friend/Family Member/Patient (Name: \_\_\_\_\_)  
 Ad (Source \_\_\_\_\_)  Other: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**Employed** FT / PT / None **Employer** \_\_\_\_\_

**Financially Responsible Person:** \_\_\_\_\_ Social Security: \_\_\_\_\_

Address \_\_\_\_\_ DOB: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**Insurance Information**

A. Insurance Company: \_\_\_\_\_  
 Subscriber Birth Date: \_\_\_\_\_  
 Subscriber SSN: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Subscriber Employed By: \_\_\_\_\_

B. Insurance Company: \_\_\_\_\_  
 Subscriber Birth Date: \_\_\_\_\_  
 Subscriber SSN: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Subscriber Employed By: \_\_\_\_\_

**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 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:** \_\_\_\_\_