Lawrenceville Foot and Ankle Specialists (LFAS)

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

Address_____

City_____ **State**_____ **Zip**_____

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

Birthdate_____ **Age**_____ ***E-Mail**_____

Social Security #_____-_____-_____ **Male Female Married Single**

Employer_____ **Title**_____ **Phone**_____

Spouse's Full Name_____

Emergency Contact_____**Phone**_____

Family Doctor/Primary Care Physician: _____**Date of Last Visit:**_____

How Did You Hear About Lawrenceville Foot and Ankle Specialists? _____

Allergies (Check All That Apply):

_____ No Known Allergies _____ Adhesive Tape _____ Aspirin _____ Codeine
_____ Cortisone _____ Local Anesthetic _____ Latex _____ Penicillin
_____ Sulfa Other_____

Have You Ever Been Treated For:

_____ Arthritis _____ Abnormal Bleeding From A Cut _____ Anemia
_____ Diabetes _____ Asthma _____ Gout
_____ Heart Problems _____ High Blood Pressure _____ Kidney Disease
_____ Low Back Pain _____ Blood clots _____ Stroke
_____ Ulcers Other_____

Smoking: No Previously Yes ____packs/day **Alcohol: No Occasionally Daily**

Chief Foot Complaint_____

Present Medical Problems _____

_____

Major Operations or Injuries _____

_____

List All Present Medications _____

_____

_____

_____

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* E-mail addresses are used for contact information only and will not be shared with anyone

Lawrenceville Foot and Ankle Specialists (LFAS)

Primary Insurance_____ **Name of Policyholder**_____

Policyholder's Social Security #_____-_____-_____ **Policyholder's Date of Birth**_____

Employer_____ **Work Phone**_____

Secondary Insurance_____**Name of Policyholder**_____

Policyholder's Social Security #_____-_____-_____ **Policyholder's Date of Birth**_____

Employer_____ **Work Phone**_____

Prescription Insurance_____ **Local Pharmacy**_____

PLEASE READ CAREFULLY BEFORE SIGNING

As part of our office policy, we require that your deductible (if not met), co-payment, and/or co-insurance be paid in full at the time of treatment. You are fully responsible for any amount not paid by insurance. Our office accepts cash, check, Visa, Mastercard, and Discover.

I hereby authorize Lawrenceville Foot and Ankle Specialists to release to my insurance company or other medical professionals any medical information acquired in the course of my examination or treatment. I also authorize payment from my insurance company to Lawrenceville Foot and Ankle Specialists for any surgical and/or medical benefits due for services rendered.

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

_____ _____

Patient/Responsible Party **Date**

IF PATIENT IS UNDER 18 YEARS OLD OR A FULL TIME STUDENT,
PLEASE COMPLETE THE FOLLOWING INFORMATION:

Mother's Name_____

Employer_____ **Work Phone**_____

Father's Name_____

Employer_____ **Work Phone**_____