Berks Foot & Ankle Surgical Associates, Inc.

PATIENT INFORMATION SHEET

Today's Date:	***Preferred Language: English (USA) Spanish Other: _____***

DEMOGRAPHICS

Last Name:	***First Name:***	***MI:***	***Sex:*** M F	***Prefered Name:***
Date of Birth:	***Home Phone #:***	***Cell phone #:***		***e-mail Address:***
Address:	***City:***	***State:***	***Zip:***	
Social Security #	***Occupation:***	***Employer:***	***Work #:***	
Pharmacy, Location:	***Family Dr:***			

Primary Insurance: ***Second Insurance:***

Race circle one: White Black/African American American Indian/Alaskan Native Asian
Native Hawaiian/Other Pacific Islander All Other Races Declined to specify/unknown

Ethnicity: Not Hispanic or Latino Hispanic or Latino

COMPLETE IF PATIENT IS A MINOR

Person Responsible for Payment:	***Relationship:***	***DOB:***
Address:	***City:*** ***State:*** ***Zip:***	***Phone#***

AUTHORIZATION TO TREAT

I hereby authorize Berks Foot & Ankle Surgical Associates, Inc. and any qualified staff to:

- evaluate, diagnose and treat my foot/ankle condition as may be deemed necessary
- take photographs, for the purpose of advancing medical education. I understand that my identity will remain confidential.

Patient or Authorized Signature _____ Date _____

If not the Patient, state relationship _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE (HIPAA)

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

Please allow the following family members to receive information:

Name: Relationship: Phone #:

_____ _____

_____

(Patient Name) PLEASE PRINT

_____

Name of Parent or Authorized Representative, if applicable

_____ _____

Signature ***Date***