Hill County Foot and Ankle Specialist
Dr. Suzanne Jenkins
904 Corsicana Hwy Hillsboro, TX 76645
Office: 254-582-9300 Fax: 254-582-9302

GERNERAL INFORMATION

Prefix: ___First Name: _____ Middle Initial: __ Last Name:_____ Suffix:___
SSN: _____ Date of Birth: _____ Gender: Female / Male

PERMANENT HOME ADDRESS AND PHONE NUMBER(S)

Street: _____
Home Phone: _____ Cell:_____ ZIP:_____
Email: _____ Work:_____

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MAILING ADDRESS: Street: _____ Zip: _____

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Race: _____ Ethnicity: _____ Language: _____ Marital Status: _____ Employment: _____

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Family Doctor Name:_____ Phone Number:_____
Pharmacy Name: _____ Phone Number:_____

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EMERGENCY CONTACT / MEDICAL RELEASE FORM (HIPPA) (I authorize the release of the following information: diagnosis, medical records, examination details and claim information.)

First Name:_____ Last Name:_____ Relationship_____ Phone Number:_____
First Name:_____ Last Name:_____ Relationship_____ Phone Number:_____

(Release of information will remain in effect until terminated by the patient in writing.)

_____ We may contact your family physician or emergency medical persons in case of emergency
_____ Our office may leave a detailed phone message at home or cell phone
_____ Our office may leave a message asking me to return your call

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FRONT DESK WILL MAKE A PHOTOCOPY OF ALL INSURANCE CARDS

CARD HOLDER INFORMATION WILL NEED TO BE FILLED OUT BELOW:

Relationship to card holder: Spouse Child Other / Card Holder Full Name:_____
DOB:_____ SSN: _____ Address of the card holder:_____
Phone Number of card holder:_____ Work Number of card holder:_____

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RELEASE AND ASSIGNMENT:

I authorize the release of any medical information necessary to process my insurance claim (s)
I authorize and request of payment of medical benefits directly to Dr. Suzanne Jenkins
I understand that I may revoke this authorization in writing at any time {by sending a signed and dated written statement to (name of person or organization and address) saying that I am revoking my authorization to disclose health records,} expect to the extent that the person (s) and/or organization (s) named above have taken action in reliance of this authorization. [NOTE: If the organization is a covered entity under HIPAA, add I further understand that my eligibility for health benefits, my enrollment in a health plan, and my treatment will not be affected by whether or not I sign this authorization] I agree that a photocopy of this may be used in lieu of the original. I understand that if my insurance fails to pay Dr. Suzanne Jenkins/Hill County Foot and Ankle Specialist in full. I am responsible for the unpaid balance. I acknowledge that HIPAA was given to me. Incase of a emergency we will release information of your PHI to provider/or facility.

Signature (Patient or Representative:_____ **Date:**_____