Date:___/___/___

Capital Foot & Ankle
Surgeons of Austin

Patient Information Sheet

First name:_____Middle Name:_____ Last name: _____

Social Security Number: _____-_____-_____ Date of Birth:_____/_____/_____ Gender:_____

Home Address: Street:_____Apt #:_____
City:_____ State:_____ Zipcode:_____
Home Phone: (_____)-_____-_____ Cell phone: (_____)-_____-_____ Work: (_____)-_____-_____
E-mail:_____ Fax: (_____)-_____-_____

Pharmacy name:_____Phone number:(____)-_____-_____
Address:_____

Insurance Information: *Please fill out so that there are no billing confusions, thank you!*
Primary Insurance:_____
Insured party name:_____DOB:_____
Social security #:_____ID #_____
Group #:_____Effective date:_____
Relationship to patient: (self, spouse, parent)_____

Secondary Insurance:_____
Insured party name:_____DOB:_____
Social security #:_____ID #_____
Group #:_____Effective date:_____
Relationship to patient: (self, spouse, parent)_____

Was this an accident? Yes or No If yes, date of accident/ injury:_____/_____/_____
Location of the accident:_____ Is an attorney involved? Name:_____

Was this a workers comp injury? _____ What body part?_____
Referred by: _____Employer: _____
Work Comp insurance:_____
Claim #:_____Adjuster name & phone #_____

Primary Care Physician:_____Phone #:_____
Date of last visit:_____/_____/_____
Medicare Patients: *In compliance with Medicare guidelines you MUST be current (seen within the last 6 months) with your PCP or endocrinologist.*
Shoe size:_____
Where did you hear about us?_____

Emergency contact:_____Phone number:(____)-_____-_____
Relationship to patient:_____

_____ _____