Welcome to the Tola Foot & Ankle Center. Thank you for filling out this Patient Information Form.

•New Patient •Updating my information.

Reason for your visit: _____ Date: _____

First Name_____ MI_____ Last Name_____ Jr Sr

Male / Female Birthdate: _____ Email:_____

Address_____ Apt.#_____ City_____State____ Zip_____

Primary Phone# _____-_____-_____ Cell/Home Secondary Phone# _____-_____-_____ Cell/Home

How did you find us? □ Dr. □ Family / friend □ Our Website □ Google □ Insurance Directory

Referred by: _____

Emergency Contact:_____ relation_____ Phone#_____

Marital status: (circle one): Single, Married, Partner, Divorced, Widowed, Student

Is a referral needed? □ Yes □ No **Referral Received**: _____

Primary Insurance_____

Copay_____ Ins Plan Name_____

ID #:_____

Group# _____

Subscriber:
First _____ Last_____

Relationship to subscriber: self spouse child

Subscriber Birth Date:_____

Secondary Insurance_____

Copay_____ Ins Plan Name_____

ID #:_____

Group# _____

Subscriber:
First _____ Last_____

Relationship to subscriber: self spouse child

Subscriber Birth Date:_____

If the patient is insured under parents plan, please complete the following:

Mother's Name_____

Address_____

City_____ State_____ Zip_____

Home Phone#_____

Work Phone#_____

Cell#_____

Legal representative: Mother Father Both

Father's Name_____

Address: same / other: _____

City_____ State_____ Zip_____

Home Phone#_____

Work Phone#_____

Cell#_____

1. CONSENT FOR TREATMENT: I give Tola Foot & Ankle Center permission to examine and treat, perform tests and procedures that are necessary in the diagnosis and/or treatment of my foot/ankle/leg disorders.
2. FINANCIAL POLICY: I certify that I (or my dependent) have coverage with my insurance and am responsible for informing the office if there is any change in my health insurance information. For my visits in this office, I assign all insurance payments to be payable to Dr. Pamela F. Tola. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I allow the release of medical information to my health insurance for payment, or requested physician for the purpose of treatment and/or to provide continuity of care. I authorize the use of this signature on all health insurance claim form submissions.
3. PRIVACY NOTICE: I certify that I have read (or had the opportunity to read if I so chose) and understand the HIPAA Notice of Privacy Practices. Our office's full HIPAA policy is available upon my request.

SIGNATURE_____ **Date**_____