SPACE COAST
Foot & Ankle Center
Specializing in Medicine & Surgery of the Foot & Ankle

DATE:____________________ FAMILY PHYSICIAN:_____________________________________
PATIENT'S NAME:____ SEX: (M) (F)
LAST FIRST MIDDLE INITIAL
ADDRESS:___________________________________ CITY:________________________ZIP:____________
HOME. PHONE:_____________________________CELL PHONE:_____________________________
D.O.B.__________________________ AGE:__________ SOC. SEC. NUMBER:________________________
NAME OF EMPLOYER:___________________________________WORK PHONE :____________________
EMERG. CONTACT:_______________________RELATION:_____________PH. NUMBER_____________
ADDRESS:____CITY:___________________ZIP:____________

RESPONSIBLE PARTY INFORMATION

INSURED NAME:____
EMPLOYER:____BUS. PHONE:___________________________
BUS. ADDRESS:____INSURED'S D.O.B.__________ _____

HEALTH INSURANCE INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE INITIAL THE FOLLOWING)

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
INSURANCE NAME:____________________________	INSURANCE NAME:____________________________
ID NUMBER:__________________________________	ID NUMBER:__________________________________
GROUP NUMBER:______________________________	GROUP NUMBER:______________________________
PLAN NUMBER:_______________________________	PLAN NUMBER:_______________________________
ADDRESS:___________________________________	ADDRESS:___________________________________
PHONE NUMBER:______________________________	PHONE NUMBER:______________________________

FINANCIAL RESPONSIBILITY: I understand and agree that regardless of my insurance status, I am financially responsible for the balance of my account. I acknowledge that I am responsible for any deductible, co-pay, or other balance not covered by my insurance carrier(s).
Co-pays and deductibles are due at time of service.
In the event my account balance becomes overdue, I hereby agree to pay interest, collection, and other legal expenses to include attorney's fees related to any collection of fees owed. _X__________

AUTHORIZATION TO TREAT: I hereby authorize any treatment(s), agreed upon with Dr. John MacKenney which may be deemed advisable._X__________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Space Coast Foot & Ankle Center for services, if any, otherwise payable to me for his/her services as described. I understand that I must provide a legible copy of my insurance cards (with claims address and telephone number). _X_________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Space Coast Foot & Ankle Center to release full details of my medical history for the purposes of healthcare management and/or for processing all medical claims on my behalf. I authorize Space Coast Foot & Ankle Center to release any information acquired in the course of treatment necessary to process claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment._X________

SECONDARY INSURANCE: I understand that billing my secondary insurance carrier is a service provided as a courtesy to me and it is my responsibility to follow up with my insurance carrier. _X__________

PATIENTS/GUARDIAN SIGNATURE____ DATE____________________