



ALOHA FOOT AND ANKLE ASSOCIATES, INC



Last Name _____ First Name _____ Middle Initial _____ Sex M F
Address _____ City _____ State _____ Zip _____
Cell phone (____) _____ Home Phone (____) _____ Work (____) _____
Social Security # ____/____/____ Age _____ Date of Birth ____/____/____
Marital status _____ Children # _____ Ages _____
Employer _____ City _____ State _____ Zip _____
Occupation _____ May we call you at work Y N Work hours _____

Spouse/Domestic Partner Information (If appropriate)

Last Name: _____ First Name _____ Middle Initial _____ Sex M F
Social Security # ____/____/____ Date of Birth _____ Phone (____) _____ Ext _____

Please select your preferred contact method for outstanding balances:

Email _____ Regular mail Fax (____) _____

Financially Responsible Party (If different from patient)

Last Name _____ First Name _____ E-mail _____
Address _____ City _____ State _____ Zip _____
Date of Birth ____/____/____ Employer _____ Phone (____) _____ Ext _____

Insurance Information (Please bring insurance card to each appointment)

Type of Insurance PPO HMO POS EPO Medicare Self Pay Workers Comp
Does your insurance require prior authorization? Yes No

Primary Insurance

Phone (____) _____ Group # _____
Address _____ City _____ State _____ Zip _____
Insured's Last Name _____ First Name _____ ID# _____
Insured's D.O.B. _____ Copay \$ _____ (required at each visit) Coinsurance % _____
Deductible _____ Amount Met _____ Limits _____

Secondary Insurance

Phone (____) _____ Group # _____
Address _____ City _____ State _____ Zip _____
Insured's Last Name _____ First Name _____ ID# _____
Insured's D.O.B. _____ Copay \$ _____ Deductible _____ Amount Met _____ Limits _____

Primary Care Physician

Phone (____) _____

Primary Pharmacy

Phone (____) _____

In Case of Emergency

Who should we notified _____ Relationship _____ Phone (____) _____

PLEASE BRING INSURANCE CARD AND A GOVERNMENT ID WE WILL MAKE COPIES FOR YOUR FILE

Please read and sign below: I directly assign all medical and surgical benefits to Aloha Foot and Ankle. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize Aloha Foot and Ankle Associates to release all information necessary to secure the payment of benefits. I understand that fees for service and insurance copays are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance. It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than thirty (30) days for payment. After thirty (30) days you will be billed for any outstanding balance on your account. All outstanding balances are due upon receipt.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT. _____ Date _____