CLEAR FORM

PRINT FORM

DR. MICHAEL Fanous
FOOT & ANKLE SURGEON
MICHAEL M. FANOUS, DPM, INC.
FAAFAS, MHA, MS

PATIENT: _____ MALE / FEMALE: _____
(Last Name, First Name, M.I.)

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____ Driver's License #: _____

HOME ADDRESS (No P.O. Boxes Please): _____

CITY: _____ STATE: _____ ZIP CODE: _____

MAILING ADDRESS (if different from above): _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: ( ) _____ - _____ CELL: ( ) _____ - _____

E-MAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____

BUSINESS PHONE: ( ) _____ - _____

SPOUSE INFORMATION: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ EMPLOYED BY: _____

BUSINESS PHONE: ( ) _____ - _____ OCCUPATION: _____

EMERGENCY CONTACT (Name of Relative or Friend Not Living With You)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: ( ) _____ - _____

PRIMARY INSURANCE

*Please Check If You Do Not Have Insurance ☐

INSURANCE CARRIER: _____ PHONE: ( ) _____ - _____

ADDRESS: _____

INSURANCE ID #: _____ GROUP/PLAN: _____

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐

AMOUNT OF CO-PAY: $ _____

SECONDARY INSURANCE

INSURANCE CARRIER: _____ PHONE: ( ) _____ - _____

ADDRESS: _____

INSURANCE ID #: _____ GROUP/PLAN: _____

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐

I, _____ authorize Dr. Michael Fanous, DPM, Inc. to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Dr. Michael Fanous, DPM, Inc. I authorize Dr. Michael M. Fanous, DPM, Inc., an out of network provider to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned or not assigned to me according to my insurance policy rule. It is the procedure of Dr. Michael Fanous, DPM, Inc. to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals.

_____ _____

Patient or Responsible Party Signature **Date**