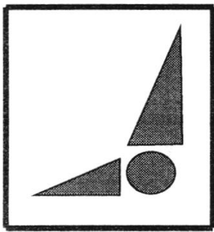

Midwest Foot & Ankle Clinics

Tel: (847) 398-8637 Fax: (847) 398-4349 Email: midwestfootandankle@gmail.com

PATIENT INFORMATION

Patient Name: ______________________________ **Social Security #:** ______________
Last Name First Name Middle Initial

Address: ______________________________ **Date of Birth:** ______________

City: ______________ **State:** ________ **Zip:** ________ **Email:** ______________

Home Phone: ______________ **Cell Phone:** ______________ **Alternate Phone:** ______________

Sex: ___**Male** ___**Female** **Marital Status:** ___**Married** ___**Single** ___**Widowed** ___**Separated** ___**Divorced** ___**Partnered for** ___**years**

Preferred language: ______________ **Race:** ___ **American Indian/Alaskan Native** ___ **Black/African American** ___ **White** ___ **Asian** ___ **Native Hawaiian/Other Pacific Islander**
Ethnicity: ___ **Hispanic/Latino** ___ **Not Hispanic/Latino**

Patient Employer/School: ______________________________ **Occupation:** ______________

Employer/School Address: ______________________________ **Employer/School Phone:** ______________

In case of emergency, who should we notify? ______________ **Phone:** ______________

Whom may we thank for referring you to our practice? ______________________________

PRIMARY INSURANCE

Subscriber / Primary Insured: ______________________________ **Relation to Patient:** ______________
Last Name First Name

Address (if different from patient): ______________________________ **Social Security #:** ______________

City: ______________ **State:** ________ **Zip:** ________ **Date of Birth:** ______________

Subscriber / Primary Insured Employer: ______________________________ **Employer Phone:** ______________

Employer Address: ______________________________ **City:** ________ **State:** _____ **Zip:** _______

ADDITIONAL / SECONDARY INSURANCE

Subscriber Name: ______________________________ **Relation to Patient:** ______________
Last Name First Name

Address (if different from patient): ______________________________ **Social Security #:** ______________

City: ______________ **State:** ________ **Zip:** ________ **Date of Birth:** ______________

Subscriber Employer: ______________________________ **Employer Phone:** ______________

Employer Address: ______________________________ **City:** ________ **State:** ____ **Zip:** _______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage with (name of insurance company(ies))______________________________ and assign directly to Dr. Khalid Husain / Dr. Jennifer Kirchens / Dr. Gene Choi all insurance benefits, if any, otherwise payable to me for services rendered. The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. Please be aware that some services provided in our office may not be covered by your co-pay and may be subject to your deductible. Our office is not aware of this until we receive the explanation of benefits from your insurance carrier.
I understand the above paragraph and agree to be financially responsible for any amount not covered by my insurance.

______________________________ ______________

Patient Signature (Parent or Guardian Signature if patient is a minor) **Date**