WENTZ FOOT & ANKLE SPECIALISTS

920 Rush Drive · Salida, Colorado 81201 · (719) 539-6600

PATIENT INFORMATION

PLEASE PRINT AND COMPLETE ALL ITEMS Date _____

Last Name _____ First _____ MI _____

Address _____
Mailing/Street Address City State Zip

Home Phone (_____)_____ Cell Phone (_____)_____ E-mail _____

Date of Birth _____ Gender M F Social Security # _____

Marital Status M S D W Spouse's Name _____ Pharmacy _____

Family Physician _____ Referring Physician _____

How did you hear about us? Insurance Internet Newspaper Phone Book Signage Web Site Word of Mouth Other _____

Employer _____ Work Phone _____ Ext _____

GUARANTOR (Individual responsible for payment of bill)

Last Name _____ First _____ MI _____

Address _____
Mailing/Street Address City State Zip

Home Phone (_____)_____ Cell Phone (_____)_____ SSN _____

Employer _____ Work Phone (_____)_____ Ext _____

PRIMARY INSURANCE (Patients not having proof of insurance at the time of service will be considered self-pay)

Insurance Company _____

Subscriber's Name _____ Subscriber's DOB _____

Subscriber # _____ Group # _____

Is this insurance through the patient's or guarantor's employer? Patient Guarantor NA

Worker's Comp/ Auto Claim Date of Injury _____ Claim # _____

Claims Adjustor's Name _____ Phone (_____)_____

SECONDARY INSURANCE

Insurance Company _____

Subscriber's Name _____ Subscriber's DOB _____

Subscriber # _____ Group # _____

Is this insurance through the patient's or guarantor's employer? Patient Guarantor NA

EMERGENCY CONTACT

Name _____ Home Phone (_____)_____ Work Phone (_____)_____

I understand that I am responsible for payment of medical expenses incurred. I hereby authorize Wentz Foot & Ankle Specialists to treat and furnish information to insurance carriers concerning my medical care and hereby assign to Dr. Ralph Wentz for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and collection costs should this account be assigned for collections.
I accept and understand the responsibility of notifying Wentz Foot & Ankle Specialists of any requirement by my insurance company for preauthorization prior to any hospital admission or surgical procedure, whether done in office or in hospital. I understand that it is also my responsibility to verify that a preauthorization has been completed prior to any hospital admission or surgical procedure. I also understand if I fail to get a referral, if necessary, I will be responsible for the charges. I understand I am responsible for checking my insurance benefits.

Signature of Patient or Authorized Representative _____

(To be completed by staff) Photo ID type/number _____ Initials _____