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, including attorney fees, 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. As a condition of receiving treatment from Wentz Foot and Ankle, I agree not to post any information on any online review sites that could be considered libelous. I agree that if I post anything online that could be considered libelous, I agree to pay Wentz Foot & Ankle attorney fees and costs expended by them to remove said libelous postings.

Signature of Patient or Authorized Representative ____

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