Berks Foot & Ankle Surgical Associates, Inc.

PATIENT INFORMATION SHEET

Today's Date:	***Preferred Language: English (USA) Spanish Other: _____***			
DEMOGRAPHICS				
Last Name:	***First Name:***	***MI:***	***Sex:*** M F	***Marital Status:*** Single / Mar / Div / Sep / Wid
Date of Birth:	***Home Phone #:***	***Cell phone #:***		***e-mail Address:***
Address:	***City:***	***State:***	***Zip:***	
Social Security #	***Occupation:***	***Employer:***	***Work #:***	
Preferred Means of Communication: (circle one) Phone Mail E-mail Fax _____				
Race: White (not Hispanic or Latino) Black Hispanic/Latino Asian American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander Other _____				
Religion: (Optional) Agnostic Atheist Baptist Buddhist Catholic Christian Episcopalian Jewish Lutheran Muslim Presbyterian Protestant Hindu				
Ethnicity: Not Hispanic or Latino Hispanic or Latino				
INSURANCE INFORMATION				
Primay:	***Subscriber Name:***	***DOB:***	***Relationship:***	
Secondary:	***Subscriber Name:***	***DOB:***	***Relationship:***	
COMPLETE IF PATIENT IS A MINOR				
Person Responsible for Payment:	***Relationship:***	***DOB:***		
Employer:	***Social Security #***	***Work #***		
AUTHORIZATION TO TREAT				

I hereby authorize Berks Foot & Ankle Surgical Associates, Inc. and any qualified staff to:

- evaluate, diagnose and treat my foot/ankle condition as may be deemed necessary
- take photographs, for the purpose of advancing medical education. I understand that my identity will remain confidential.

Patient or Authorized Signature _____ Date _____

If not the Patient, state relationship _____