# Patient Information

Name:_____ Date:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Age:_____ Birth Date:_____ Gender: M F Marital Status: S M D W

Social Security #:_____

Occupation: _____ Employer:_____ City & State:_____

| Spouse/Parent Information | Occupation: |
|---|---|
| Spouse/Parent Name: | Employer: |
| Date of Birth: | City |
| Social Security: | Work Phone: |

## INSURANCE INFORMATION

Medicare? Yes No Primary Secondary Medicare #:_____

**Primary Insurance Name**:_____

Group #:_____ I.D. #:_____ Insured Name:_____

Social Security #:_____ Relationship to the Insured (Circle One): Self Spouse Parent

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**SECONDARY INSURANCE**:

SECONDARY INSURANCE COMPANY:_____

Group #_____ I.D. #:_____ Insured Name:_____

Social Security #:_____ Relationship to the Insured (Circle One): Self Spouse Parent

I hereby give permission to Dr. Francis Kania and his office staff to release any information requested by my insurance company acquired in the course of my examination and treatment. I authorize payment directly to Dr. Francis Kania for my medical and/or surgical benefits otherwise payable to me for provided services. I understand that I am financially responsible for all charges. I give permission to Dr. Kania and his associates to evaluate, diagnose, and upon my approval, treat my foot and / or ankle condition.

Signature:_____ Date:_____ Relationship: Self Spouse Parent