COMPLETE FEET
& ANKLE CARE

Address: 2905 W. Warner Road Ste #20 Chandler, AZ 85224
Phone: 480-933-0801
Fax: 480-933-0476
URL: www.greggkrahndpm.com

Patient Name: _____
Address (local): _____
City: _____ State: _____ Zip: _____
Second Address: _____
City: _____ State: _____Zip: _____
Phone#: ( ) _____
Responsible Party: _____
Relationship to Patient: _____
Responsible Phone#: _____
In Case of Emergency contact: _____

Responsible Social Security #: _____
2nd Phone (cell or other): _____
Birthdate: _____/_ /_____ (Patient)
Age: _____
Sex: M/F: _____
Driver's License #: _____
Marital Status: S M W D Sep

Emergency Phone#: _____

Employment Information:

Patient's Employer: _____ Phone: _____
Spouse/Responsible Party Employer: _____ Phone: _____

Insurance Information - Please allow us to copy your insurance ID cards

1. Primary Insurance Company: _____
   Insurance Company address: _____
   _____
   Insurance Company Phone#: _____
   Insured or Employee Name: _____Sex: M/F

   Effective Date: _____
   Relationship to Patient: _____
   Group#: _____
   ID#: _____
   Insured Date of Birth:_____

---

2. Secondary Insurance Company: _____
   Insurance Company address: _____
   _____
   Insurance Company Phone#: _____
   Insured or Employee Name:Sex: M/F _____

   Effective Date: _____
   Relationship to Patient: _____
   Group#: _____
   ID#: _____
   Insured Date of Birth:_____

Accident Information WORK, AUTO, HOME, OTHER:_____

Date: _____ How/Where: _____
_____
Were you treated by another Dr. for this injury? Yes No_____

Work Related: Yes No
Have you filed a claim: Yes No
Doctor's Name: _____

Family Dr.: _____ Phone#: _____
Referred by: _____ (family, doctor, friend, insurance company, other) _____
Why are you in to see the doctor?_____

I HEREBY GIVE MY PERMISSION TO ADMINISTER TREATMENT, AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN DIAGNOSIS AND TREATMENT. I ALSO AGREE TO PAY FOR THE SERVICES IN THE FOLLOWING WAY: (please circle)

1. Cash or Check at the time of treatment.
2. Credit Card at the time of treatment.
3. I hereby assign insurance information and I agree to pay my co-payment, deductible, and non-covered portions.
4. I hereby give permission to my physician to release records to process my insurance claims. I acknowledge that I was provided the opportunity to review the HIPAA Notice of Privacy Practices and understand my privacy will be protected to the HIPAA standards._____

WE RESERVE THE RIGHT TO CHARGE YOU A FEE FOR YOUR MISSED VISIT IF YOUR 24 HOUR NOTICE OF CANCELLATION IS NOT GIVEN. A MISSED APPOINTMENT HURTS THE CARE OF TWO PEOPLE; YOURS AS WELL AS THE PATIENT WAITING FOR AN APPOINTMENT._____

Patient Signature: _____ Date: _____
(Parent or Guardian if a minor)