FOOT CENTERS OF NC, P.A.

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Patient Demographics, Contact Information & Consent Form

Name: ____________________________________ ☐ Male ☐ Female SS #: _____ - ______ - ______ Status: ☐ Single ☐ Married

Address: ____ ____
CITY STATE ZIP CODE

Birthday: _____ /_____/______ Age: _________ Home Phone #: _____ -_____ - _______ Cell Phone #: _____ - _____ - ________

*Email address: ___________________________ Race/Ethnicity: ________________ Primary Language: ______________________
(see pg. 3 providing your email address)

Employer: ________________________________ Work #: _____ - ______ - _______Occupation: ____________________________

Policy Holder: ________________________________ Relationship: ________________________ SSN# ______ - ______ - ______

Policy Holder's Employer: ____ Date of Birth: ________/_______/_______

Responsible Party other than patient: ☐ Patient is under 18 ☐ Patient has a Power of Attorney (Please provide documentation)
Name: _______________________________ Relationship: _______________________ Date of Birth: ______/______/_______

Address: _____________________________________ City: ______________________ State: ______ Zip Code: ____________
Please list your doctors and pharmacy information in order for us to coordinate your care:

Physician's Name	Phone Number	City	Date Last Seen
Primary ___________________________________	____ - ____ - ______	_________________________	_____/_____/_______
Specialist _________________________________	____ - ____ - ______	_________________________	_____/_____/_______
Pharmacy _________________________________	____ - ____ - ______	_________________________	_____/_____/_______

Did you sustain an injury at work? Y N Are you covered under an employer or union policy? Y N
Are your injuries accident related? Y N Is your spouse or other family member employed? Y N
Are you currently employed? Y N Do you have a secondary insurance policy? Y N

How did you hear about us? ☐ Phone Book – which city directory? _______________________

☐ Family/Friend _________________ ☐ Co-worker ________________ ☐ Special Event/Health Fair___________________

☐ Family Doctor______________________ ☐ Internet/Web Site ☐ Insurance Directory ☐ Other: _________________________

Your signature below allows us to bill your insurance carrier for your services and accept payment for these services. Any amount not covered by your carrier will be billed directly to you after preferred provider discounts are applied. Fees for services that are denied by your insurance carrier as "non-covered" or "not medically necessary" are your responsibility. Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

You further give FCNC permission to access any database available to collect and update my medication list.

In addition, (as required by NC Dept. of Public Health and OSHA regulations), in the event that a healthcare worker is exposed to my blood or other bodily fluid, I agree to have my blood tested, at no charge to me, for Hepatitis B, Hepatitis C and HIV following an exposure incident. I understand that an exposure incident does not put my own health at risk. I further understand that the results of my blood test will be discussed with me, used to determine the need for treatment of the health care worker, if any, and otherwise will remain in my confidential medical records with the health care provider who conducts the test.

Patient Signature: ____ **[SEAL]** Date: ______________________________

Witness Signature: ____Date: ______________________________