AKAMAI FOOT DOCTOR, LLC	ACCT #	TYPE	DR #	DATE

PATIENT INFORMATION

LAST NAME*			FIRST NAME*		M.I.
Sex* ( )M ( )F	Social Security Number	Date of Birth*	Marital Status ( ) Single ( ) Married ( ) Divorced ( )Widowed		
Address*			Unit/Apt/Suite	Primary Phone*	
City*		State*	Zip Code*	Alternative Phone*	
Employer Name/ Address*				Email Address*	
Gaurantor Name/ Address*				Garantor Phone*	
Referring Doctor*	Phone*	Primary Care Doctor (If different from referring)*		Phone*	
If Primary Doctor is out-of-state, please provide address and phone number					
PRFERED PHARMACY 1*		**PRFERED PHARMACY 2***			

EMERGENCY

EMERGENCY CONTACT #1*			
Last Name	First Name		M.I.
Address	Phone	Relation to Patient	
EMERGENCY CONTACT #2*			
Last Name	First Name		M.I.
Address	Phone	Relation to Patient	

INSURANCE

PRIMARY INSURANCE NAME:	Subscriber Name	Sex ( ) M ( ) F	Birthdate
Address:	Subscriber Employer	Relationship to Patient	
Phone:	Policy Number/ID/Subscriber SSN	Effective Date	
SECONDARY INSURANCE NAME:	Subscriber Name	Sex ( ) M ( ) F	Birthdate
Address:	Subscriber Employer	Relationship to Patient	
Phone:	Policy Number/ID/Subscriber SSN	Effective Date	
TERTIARY INSURANCE NAME:	Subscriber Name	Sex ( ) M ( ) F	Birthdate
Address:	Subscriber Employer	Relationship to Patient	
Phone:	Policy Number/ID/Subscriber SSN	Effective Date	

What is your reason for today's visit?*	When did this start?

AUTHORIZATION TO RELEAE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: I authorize Dr. Natahlie E. Sowers and Akamai Foot Doctor, LC and its representative to release my insurance company or its representative any information icluding the diagnosis and the records of ny treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

FINANCIAL AGREEMENT: Iunderstand that I am financially responsible for all charges whether or not paid by insurance. These include deductible for charges at the time of services, including, but not limited to, preliminary payment for consult /visit charge payable by cash or credit card olny. I agree to pay a late payment fee of 1% a month on any unpaid balance over 180 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attoenery or collection agency. I also agree to pay a $25 processing fee for each check returned.

I certify that the insurance information I have provided is correct. I permit copy of this authorization to be used on place of the origianl. This authorization is valid until revoked by me in writing.

Patient/ Parent/ Guardian Signature **Relationship to Patient** **Date**

Form: AFD_RegDemographicSheet
Revised: 10/03/2018