DR. MARK W. SHAFFER
FOOT and ANKLE SPECIALIST

"WELCOME TO OUR OFFICE"

PATIENT'S NAME _____ HOME/CELL PHONE _____
ADDRESS _____ WORK PHONE _____
CITY/STATE _____ ZIP CODE _____

SOCIAL SECURITY NO. _____ BIRTHDATE _____
MARRIED SINGLE DIVORCED WIDOWED (please circle) AGE _____

PATIENT OR RESPONSIBLE PARTY'S:
EMPLOYER _____
ADDRESS _____
CITY/STATE _____ ZIP _____
OCCUPATION _____

IF PATIENT IS AGE 18 OR YOUNGER, PARENTS PLEASE COMPLETE:
MOTHER/FATHER/GUARDIAN NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
HOME PHONE _____ WORK PHONE _____

WHAT IS THE MAIN CONCERN YOU HAVE ABOUT YOUR FEET OR ANKLES?
_____
_____

WERE YOU INJURED ON THE JOB? YES NO DATE OF INJURY _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO NAME _____
INSURED'S NAME _____ INSURED BIRTHDATE _____
POLICY NO. _____ GROUP NO. _____
IS INSURANCE THROUGH EMPLOYER? YES NO COVERAGE EFFECTIVE DATE _____
PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER _____

SECONDARY INSURANCE CO NAME _____
INSURED'S NAME _____ INSURED BIRTHDATE _____
POLICY NO. _____ GROUP NO. _____
IS INSURANCE THROUGH EMPLOYER? YES NO COVERAGE EFFECTIVE DATE _____
PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? (PLEASE CIRCLE)
DOCTOR: _____ PATIENT: _____
SAW SIGN YELLOW PAGES OTHER: _____
ATLANTA GWINNETT MONROE (please circle)

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) ..... SHE WILL COPY THE CARD(S) AND RETURN THEM TO YOU. NOTHING WILL BE SUBMITTED TO YOUR INSURANCE COMPANY WITHOUT YOUR KNOWLEDGE AND PERMISSION!