**Advanced Foot & Ankle Specialists, P.C.**
**Dr. Scott A. Amoss, DPM**
**Podiatrist/Surgeon/Wound Specialist**
**Phone: (732) 350-0100 Fax: (732) 350-0147**

*Welcome to our Office*

Please fill out this form COMPLETELY, write N/A where Not Applicable applies and sign. Thank you.

| **First Name:** **M:** | **Last Name:** |
|---|---|
| Social Security# | E-mail: |
| Date of Birth: / / | □Single □Married □Other _____ |
| Gender: □ Male □ Female | Shoe Size: |
| Address: | City: State: Zip: |
| **Cell Phone:** ( ) | **Home Phone:** ( ) |
| Emergency Contact: | Contact Phone: ( ) |
| Vascular Physician: | Primary Physician: |
| Endocrinologist: | Employer: |
| Pharmacy: Location: | Phone: |
| How did you hear about our office? | |
| Reason for today's visit: | |
| **Primary Insurance Company** | **Secondary Insurance Company** |
| Insurance's Name: | Insurance's Name: |
| Policy Holder Name: | Policy Holder Name: |
| Policy ID: | Policy ID: |
| Policy Holder SSN: | Policy Holder SSN: |
| Policy Holder DoB: / / | Policy Holder DoB: / / |
| Co-pay? Yes Amt $ or NO | Co-pay? Yes Amt $ or NO |
| Referral Required: YES NO | Referral Required: YES NO |

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF.
I UNDERSTAND THAT IT IS AS A COURTESY THAT THE DOCTOR ACCEPTS MY INSURANCE FOR PAYMENT AND THAT IF FOR ANY REASON THEY DO NOT PAY MY BILL THAT I AM RESPONSIBLE.

□ I have received the Confidentially Agreement (HIPAA) and agree to comply with all its terms.

Patient's Signature: _____ Date: _____

Patient's Name Printed: _____