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: _____