Ankle and Foot Institute

Richard F. Wittock, D.P.M.
(636) 717-1100

SSM - St. Clare Health Center
St. Francis Physician Office Building
1011 Bowles Avenue
Suite 123
Fenton, MO 63026

Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

How did you find out about our office (Doctor, Friend, Phone Book, Insurance Book, etc.)?_____

Patient Name _____

Address _____ City_____State ____ Zip_____

Home Phone _____ Cell Phone _____Work Phone _____

Date of Birth_____ Sex: Male Female Marital Status: S M D W

Soc. Sec.#_____ E: MAIL: _____

Employer Name _____ Occupation _____

Employer Address _____

Emergency Contact_____ Relationship _____

Emergency Home Phone _____ Emergency Work Phone _____

Responsible Party (if different from above)

Responsible Party _____ Relationship to Patient _____

Address _____

Date of Birth_____ Sex: Male Female Social security # _____

Employer Name _____ Home#_____Work#_____

Insurance Information

Policy #1 Insurance _____ Policy# _____Phone# _____

Policy Holder Name_____ Relationship to Patient_____Date of Birth _____

Policy #2 Insurance _____ Policy# _____Phone# _____

Policy Holder Name_____ Relationship to Patient_____ Date of Birth _____

Policy #3 Insurance _____ Policy# _____Phone# _____

Policy Holder Name_____ Relationship to Patient_____Date of Birth _____

Authorization and Assignment of Benefits

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims, provided verification of your insurance policies allows assigned benefits and coverage for the services rendered. You are responsible for any pre-authorization or referral from your primary care physician that is required by your insurance company before you arrive for your visit. Please note we do not accept cases involving personal injury or workman compensation.

I hereby authorize payment directly from my insurance carrier to Ankle and Foot Institute for the benefits due to me for any outstanding claim. I further authorize the release of any medical information necessary to process this claim. I consent to the treatment as necessary or desirable to the care of the patient named above. I also acknowledge full responsibility for the payment of such services should my insurance company fail to make payment for services rendered. **A $50.00 charge will be added for appointments not cancelled within 24 hours.**

Signature _____Date _____