Queen City Foot & Ankle Specialists

Patient Information

Patient Name: _________________Middle:______________________Last:________________________________

Date of Birth: __________________ Home Phone: _______________________________

Cell Phone: __________________________ E-MAIL: ____

Address: ____

City: _______________________________ State: ________________________ Zip: _______________________

Primary Care Doctor: _________________________ Practice Name & Phone: ______________________________

Pharmacy Name: ____________________________ City & Street: _______________________________________

Emergency Contact: Name____________________________ Phone: ______________________________

Did you have any surgeries within the past year? ____

Did you have any medical condition/medication or allergy changes within the past year?

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HIPPA Acknowledgement: I hereby acknowledge that I have been made aware that Queen City Foot and Ankle Specialists (QCFAS) has a privacy policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and has made this policy available to me. I am entitled to a copy of the privacy policy upon request.

I authorize the release of any previous exams, results or images in the event QCFAS is in need of them to help with the diagnosis or treatment of my conditions. I understand and acknowledge that I am personally responsible for the services rendered at this facility. QCFAS will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

I authorize QCFAS (Dr. Roxanne Burgess, whomever they designate) to examine, administer treatment and to perform such general procedures as she (they) may deem necessary in the diagnosis and/or treatment of my condition(s). I further certify that to the best of my belief and knowledge the information provided on my personal health history is true, accurate and complete. I also authorize the physician designated to release information acquired in the course of my examination and treatment.

Patient or Guardian Signature X: ____

Printed Name: ____

Date: ____