



**ORTHOPEDIC
FOOT & ANKLE CENTER**

300 POLARIS PARKWAY, SUITE 2000
WESTERVILLE, OHIO 43082
OFFICE 614.895.8747 FAX 614.895.8810

Please present insurance cards.
Payment is expected at the time of service.

Patient Information

Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Marital Status: _____
Male: _____ Female: _____
E-mail: _____
I authorize OFAC and FootsourceMD to
communicate via e-mail. Yes / No
SS #: _____
Birth date: _____
Employer: _____
Work Phone: _____

ALTERNATE CONTACT INFORMATION

***Note: Please list a phone number that is not a
patient phone number.***

Name: _____
Relationship: _____
Phone: _____

Referring Doctor: _____
Address: _____
Phone Number: _____

Family Doctor: _____
Address: _____
Phone Number: _____

WORKER'S COMPENSATION INFORMATION

Is this a work related injury?
YES NO

Insurance Information

Primary Ins.: _____
Policyholder: _____
SS #: _____
Relationship: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Birth date: _____
Employer: _____
Work Phone: _____

Secondary Ins.: _____
Policyholder: _____
SS #: _____
Relationship: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Birth date: _____
Employer: _____
Work Phone: _____

Tertiary Ins.: _____
Policyholder: _____
SS #: _____
Relationship: _____

NON WORK RELATED ACCIDENT?

Is this injury due to an Accident (non work)?
YES NO

OFAC does not honor advanced directives. OFAC will call 911 to provide life support when in distress.

* I certify that the information provided above is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether they are covered by my insurance or not.
* I agree to be held responsible for any collection fees which may be added to my account if collection action occurs. I am aware, after 4 statements and 2 courtesy phone calls, my account may be sent to a collection agency.
* I authorize the release of medical information necessary to process my healthcare claims.

Signature: _____ **Date:** _____
If the patient is a minor, please provide the parent or guardians information.
Address: _____
Home Phone: _____ SS #: _____

United Healthcare Patients:
United healthcare will not cover any services with a diagnosis of corns or calluses as they consider this routine foot care. I agree to be financially responsible for these services.

Signature: _____ **Date:** _____
If the patient is a minor, please provide the parent or guardians signature.

By initialling here I acknowledge I have received OFAC's financial policy. _____