BFA
Bay Foot & Ankle Center

BFAC Patient Insurance Form

PATIENT INFORMATION

Last Name: First: Middle Initial: Suffix:

Street Address:

City: State: Zip:

Phone (Home): (Cell): (Work):

E-mail address:

Date of Birth: / / Age: SSN: Sex:

Marital Status: ☐ Married ☐Single ☐Divorced ☐Widowed Employer:

Referral source to Bay Foot and Ankle Center:

INSURANCE INFORMATION

Primary Insurance: Phone number:

Address of primary insurance carrier:

Insured Name: Insured SSN: Insured ID:

Policy Group #: Effective date: / / Co-payment: $

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐Other

Insurance Type: ☐ PPO ☐EPO ☐ HMO ☐ POS ☐ Self Pay ☐Medicare ☐ Medicaid
☐ Other (please specify)

Secondary Insurance (if any): Phone number:

Address of secondary insurance carrier:

Insured Name: Insured SSN: Insured ID:

Policy Group #: Effective date: / / Co-payment: $

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐Other

Insurance Type: ☐ PPO ☐EPO ☐ HMO ☐ POS ☐ Self Pay ☐Medicare ☐ Medicaid
☐ Other (please specify)

I authorize assignment of all medical and surgical benefits to Dr. Francia T. Squatrito, DPM for all future visits including today's and also authorize the doctor to release any information necessary to secure payment of benefits. I also acknowledge that I am financially responsible for any fees whether or not they are paid by insurance.

Patient or Legal Guardian Name x Signature Date / /