DR. ROBERT E. NEVILLE & ASSOCIATES, P.A
MEDICAL AND SURGICAL SPECIALIST OF THE FOOT AND ANKLE

PATIENT INFORMATION (please print clearly with full detail)

Date:____/____/____ Whom may we thank for your referral?_____
Patient's last name:_____ Patient's first name:_____ MI___ Age:___
DOB:_____ Male__ Female__ Social Security #_____ Marital Status: S__M__D__W__

Address_____ City_____ State_____ Zip_____
Home#:◯_____ Cell #:◉_____ Please Check box for Primary phone
Email _____
(email necessary for patient portal access, appointment reminders and statements)

Race: ◉ American Indian or Alaska Native ◯Asian ◯Black or African American
◯ Native Hawaiian or Other Pacific Island ◯ White◯ Other Race ◯ Decline to specify

Ethnicity: (check): ◉ Hispanic Latino ◯ Not Hispanic ◯Unreported/Declined
Preferred Language if not English: _____

Patient's Employer_____ Occupation_____
Emergency Contact Name_____ Number_____

RESPONSIBLE PARTY INFORMATION

Last Name_____ First Name_____ DOB_____ Age_____
Address_____ City_____ State_____ Zip_____
Male___ Female____ Home Phone_____ Work Phone_____
Social Security #_____ Employer_____

INSURANCE INFORMATION (Please give your insurance card to the receptionist along with driver's license or photo ID)

Insurance Company_____ Insurance Phone#_____
Subscriber/Medicare ID#_____ Group #_____ PPO__POS__EPO__HMO____
Subscriber's Last name_____ First Name_____ DOB_____
Employer_____ Phone Number_____
Secondary Insurance: Company_____ Subscriber ID#_____

FRIENDS & FAMILY CONTACTS TO RELEASE MEDICAL INFORMATION TO

By my signature below, I hereby authorize Dr. Robert E. Neville & Associates PA to release information to the following people that may inquire about my treatment, lab results, prescriptions and other health information. I understand that this authorization remains valid unless rescinded in writing. Please note in an emergency situation or other situations outlined in our Notice of Privacy Practices, we may share information with those who are not specifically listed on the form below: . If you would like a copy of our Notice of Privacy Practices, please notify our front desk at the time of check in. Please list those persons including family, and friends with whom we may share your medical information

Name: _____ Relationship:_____Phone #:_____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

I, the undersigned acknowledge that the information I have provided above is accurate to the best of my knowledge. I have been offered a copy and understand the Notice of Privacy Practices. I understand that the release of medical information to the above names contacts remains valid unless rescinded in writing.

Signature of Patient/Guardian:_____ Date_____

Relationship of Guardian to Minor Child: _____