Southwestern Foot & Ankle Associates, P.C.
11500 Highway 121, Building 700, Ste. 710
Frisco, TX 75035
Phone: 972-335-9071 Fax: 972-335-8920
Dr. Thomas H. Tran

Date:_____ Home Phone ( )_____

Patient Information (Please Print) Email: _____

Name: _____ SS/Patient ID # _____
Last Name First Name Middle Initial (required)

Address_____ Cell Phone ( )_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthday_____ ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

Patient Employer_____ Occupation_____

Employer address_____ Employer phone ( )_____

Primary Physician Name:_____ Phone Number: ( ) _____

Address:_____ Fax ( )_____ Email: _____

Primary Insurance:_____

Person Responsible for Account_____
Last Name First Name Middle Initial
Relation to Patient_____ Birthday_____ Soc. Sec. # _____

Address (If different from patient's)_____ Phone ( ) _____

City_____ State_____ Zip _____

Person Responsible Employed by _____ Occupation_____ Bus. Phone ( )_____
_____

Business Address_____ City_____ Zip Code _____ Insurance Name_____

Contact # ( )_____ Group #_____ Subscriber #_____

Additional Insurance:_____ Is Patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber name_____ Relation to Patient_____ Birthday_____

Address (If difference from patient's)_____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone ( )_____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____
Name of Insurance company (ies)
and assign directly to Dr. Thomas H. Tran all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Guardian or Personal Representative Date

_____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to patient