Dr. Shane D. Draper & Dr. Quinn D. Lindstrom
Foot and Ankle Specialist
Patient Information

Name_____Date of Birth_____
Mailing Address_____City/State_____Zip_____
Home Phone_____Cell Phone_____Social Security #_____
Marital Status: S M D W Sex: M F Employer/Address_____
Occupation_____Work Phone #_____
Name of Emergency Contact_____Phone#_____
Pharmacy Normally Used_____Referred By_____
Primary Care Physician_____
Insurance Coverage?_____If Not, Payment In Full Is Required at Time of Service

PRIMARY INSURANCE – We will need to make a copy of your insurance card, front & back
Insurance Company_____Policy Holder_____
ID#_____Group#_____
Policy Holder Date of Birth_____Relationship to Patient_____
Policy Holder Social Security#_____Address:_____
Policy Holder Employer/Address_____

SECONDARY INSURANCE – We will need to make a copy of your insurance card
Insurance Company_____Policy Holder_____
ID#_____Group #_____
Policy Holder Date of Birth_____Relationship to Patient_____
Policy Holder Social Security#_____Address:_____
Policy Holder Employer/Address_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Shane Draper and Dr. Quinn Lindstrom to help determine appropriate treatment. If there is any change in medical status, I will inform Dr. Shane Draper or Dr. Quinn Lindstrom. I give permission to Dr. Shane Draper or Dr. Quinn Lindstrom to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my lower extremities. I authorize my insurance company to pay to Dr. Shane Draper or Dr. Quinn Lindstrom, all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Shane Draper or Dr. Quinn Lindstrom to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____

Print Name_____

COPAY OR PAYMENT IS DUE AT TIME OF TREATMENT