Canton Foot & Ankle Specialists P.C.
43050 Ford Road, Suite #150 Canton, MI 48187
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www.Cantonfoot.com Dr. Brandon Semma, D.P.M.

****ANYTHING WITH AN * *MUST BE* COMPLETED****

PATIENT INFORMATION

***Patients Name:** _____ ***DOB:** _____ ***SSN:** __ __ __ - __ __ - __ __ __ __

***Sex:** □ **Male** □ **Female** ***Height:** _____ ***Weight:** _____ ***Shoe Size:** _____

***Street Address:** _____ ***City/State/Zip:** _____

***Primary Phone:** _____ **Secondary Phone:** _____ ***Text Option:** □ **Yes** □ **No**

***Email:** _____

Marital Status: □ **Single** □ **Married** □ **Widow** □ **Minor** □ **Separated** □ **Divorced** □ **Partnered for** _____ **years**

Occupation: _____ **Employer/School:** _____

Employer/School Address: _____

***Primary Care Provider: (PCP/Family Physician):** _____

***PCP Address:** _____ ***Phone:** _____

***Pharmacy:** _____ ***Phone:** _____

***Pharmacy Address:** _____

EMERGENCY CONTACT INFORMATION

***Emergency Contact/Guardian Name:** _____ ***Phone:** _____

***Relation:** □ **Parent/Guardian** □ **Spouse** □ **Sibling** □ **Relative** □ **Other:** _____

***Who may we thank for referring you?** _____

MEDICAL INSURANCE INFORMATION

***Who is responsible for this account?** _____ ***Relation to Patient:** _____

***Primary Insurance:** _____ ***ID:** _____

Secondary Insurance: _____ **ID:** _____

IF YOU ARE SELF-PAY, PLEASE CHECK THIS BOX: □ **CASH/SELF-PAY**

ASSIGNMENT & RELEASE:

I certify that I, and or, my dependent(s) have the insurance coverage listed above and assign directly to Dr. Brandon Semma 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 my insurance. I authorize the use of my signature on all insurance submissions. The above-named Podiatrist may use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

***Signature** ***Date**