Timpanogos Foot & Ankle

Dr. Spencer L. Mortensen DPM

<table>
<tr><th colspan="4">PATIENT INFORMATION</th></tr>
<tr><td colspan="2">Name:</td><td>Date of Birth:</td><td>Phone:</td></tr>
<tr><td colspan="2">Mailing Address:</td><td>City</td><td>State: | Zip:</td></tr>
<tr><td colspan="2">E-mail Address:</td><td colspan="2" rowspan="2">Race/Ethnicity: ❑American Indian or Alaskan Native
❑ Native Hawaiian or other Pacific Islander
❑ Black/African American ❑ Asian
❑ White ❑ Hispanic/Latino</td></tr>
<tr><td>Sex: ❑ Male
❑ Female</td><td>Preferred Language:</td></tr>
<tr><th colspan="4">EMPLOYMENT INFORMATION</th></tr>
<tr><td>Employed: ❑ Yes
❑ No</td><td colspan="2">Employer:</td><td>Occupation:</td></tr>
<tr><th colspan="4">RESPONSIBLE PARTY INFORMATION</th></tr>
<tr><td colspan="2">Person Responsible for Medical Expenses:</td><td>Relationship to Patient:</td><td>Phone:</td></tr>
<tr><td colspan="2">Address (If different from above):</td><td>City</td><td>State: | Zip:</td></tr>
<tr><th colspan="4">PRIMARY INSURANCE INFORMATION</th></tr>
<tr><td colspan="2">Insurance Company:</td><td colspan="2">Policy Number:</td></tr>
<tr><td colspan="2">Policyholder’s Name:</td><td colspan="2">Relationship to Patient:</td></tr>
<tr><td colspan="2">Address of Insurance Company:</td><td>City:</td><td>State: | Zip:</td></tr>
<tr><th colspan="4">SECONDARY INSURANCE INFORMATION</th></tr>
<tr><td colspan="2">Insurance Company:</td><td colspan="2">Policy Number:</td></tr>
<tr><td colspan="2">Policyholder’s Name:</td><td colspan="2">Relationship to Patient:</td></tr>
<tr><td colspan="2">Address of Insurance Company:</td><td>City:</td><td>State: | Zip:</td></tr>
<tr><th colspan="4">EMERGENCY CONTACT INFORMATION</th></tr>
<tr><td colspan="3">Personal Contact In Case of Emergency (Other than Spouse):</td><td>Relationship to Patient:</td></tr>
<tr><td colspan="3">Address City State Zip</td><td>Phone:</td></tr>
<tr><th colspan="4">AUTHORIZATION</th></tr>
<tr><td colspan="4">I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to Dr. Ryan D. Taylor for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.</td></tr>
<tr><td colspan="3">Patient/Guardian Signature:</td><td>Date:</td></tr>
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