Request visits for facilities

Facility:________________________________ Apt#/Room__________________

Resident Name:__________________________________DOB:________________

Resident Phone Number(s):____

Will the consent be signed by the Resident at visit? _________________________

POA or emergency contact name & phone number:_________________________

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Who is requesting the services of Wiles Foot & Ankle?_______________________

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Primary care group / Physician /Assistant / Nurse practitioner:________________

Please list their name and any contact information you may have

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Facility use only:

***Purpose of this form is to obtain **current** history & physical and Insurance from Primary care physicians and continue continuation of care with them.

***If the patient's **current** insurance cards are available you may include them along with this form.

***Consents will be obtained by Wiles Foot and Ankle through POA's prior to visits or patients at their first visit.

NOTICE FOR MEDICARE CARDS:

eg, 111-11-1111-A (all numbers and with letter A combos are no longer active cards) eg,

1BB1-BB1-BB1 (cards with numbers and letters are active and good)

www.wilesfootandankle.com

PLEASE SEND ALL CORRESPONDENCE TO WILES FOOT AND ANKLE:

FAX: 423-760-3660 E-MAIL OFFICE@WILESFOOTANDANKLE.COM